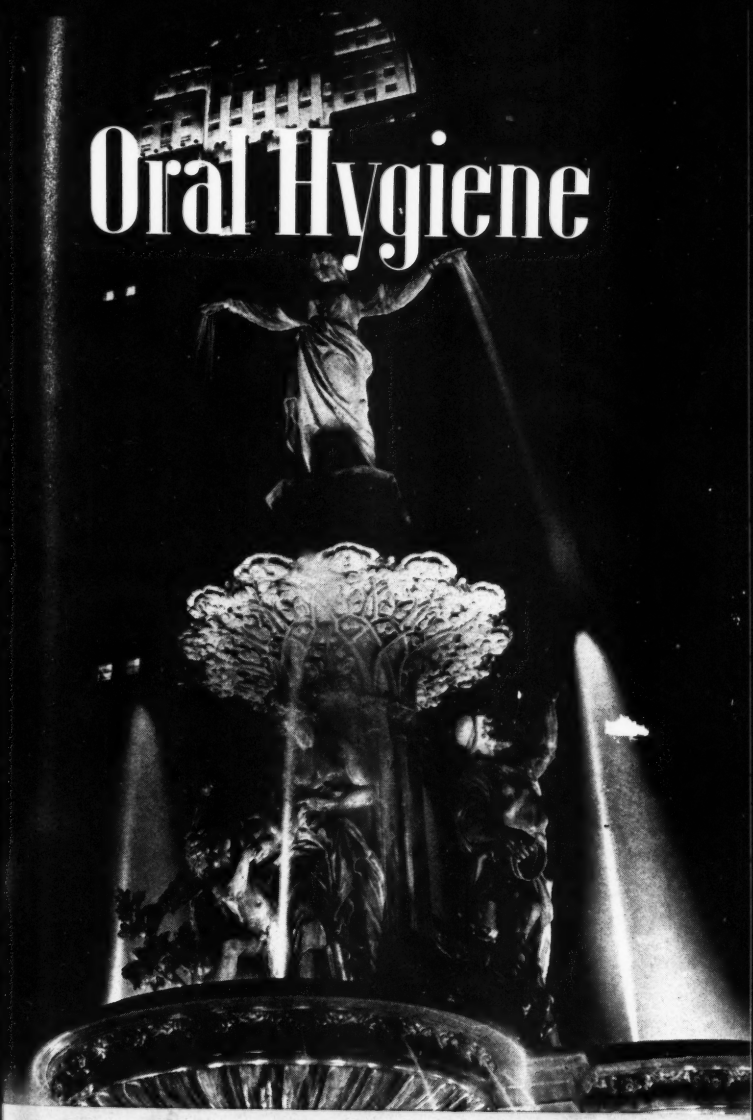
Oral Hygiene



e Tyler-Davidson Fountain in the heart of downtown Cincinnati, where the Annual
rch Clinic Meeting of the Cincinnati Dental Society will be held on March 23 to 25.

MARCH
1958

In this issue:

AN ESTATE PLAN FOR THE YOUNGER DENTIST

NOW—2-year results re-confirm effectiveness of CREST—the stannous fluoride dentifrice

HOW TO INCREASE HER BETWEEN-VISIT PROTECTION AGAINST DECAY



Today, when you instruct your patients in home tooth care routine, consider whether your recommendations take modern dental research into account.

Does the dentifrice you prescribe strengthen enamel against decay action? Is its effectiveness established by numerous studies reported in leading dental journals?

Study after study of Crest's effectiveness has been reported in leading dental journals. *All studies showed that Crest reduced dental caries in both children and adults, by an average of approximately 40 per cent.*

Now, still another report[1], published in the August 1957 *Journal of the American Dental Association*, again confirms the pronounced effectiveness of the Crest stannous fluoride formula.

Adults who used only Crest Toothpaste for 2 full years had 34 per cent fewer new carious lesions than adult users of a control dentifrice.

Make sure that your patients get the between-visit protection from dental caries so clearly shown by Crest's unparalleled clinical record.

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FLUORISTAN is Procter & Gamble's registered trademark for an exclusive combination of stannous fluoride and a fluoride-compatible polishing agent.

Crest TOOTH PASTE —fluoristan

PROCTER & GAMBLE
Office, Division of Dental Research
Cincinnati 1, Ohio

[1]Muhler, J. C. and Radike, A. W.: Effect of a dentifrice containing stannous fluoride on dental caries in adults. II. Results at the end of two years of unsupervised use. J.A.D.A. 55:196 August 1957.

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TOTAL EFFECT
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References: 1. Krantz and Carr: The Pharmacologic Principles of Medical Practice, 1954. 2. Goodman, Louis S. and Gilman, Alfred: The Pharmacological Basis of Therapeutics, sec. ed. 1955. 3. Hammes, E. M., Jr.: Pain-Relieving Drugs, J. Lancet 79:67, Feb. 1952.

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East Indian tree of the genus *Sterculia urens* from which Karaya gum is derived.

The Publisher's

CORNER

By Mass



No. 440

DEAR OLD GOLDEN SCHOOL DAYS

DOCTOR ERNEST W. CLEGG of the British Royal Air Force, now practicing dentistry at 6677 Delmar Boulevard, St. Louis, wrote to the CORNER the other day concerning the discussion in these pages of Doctor Greene Vardiman Black's name. "It reminds me of this incident," said Doctor Clegg.

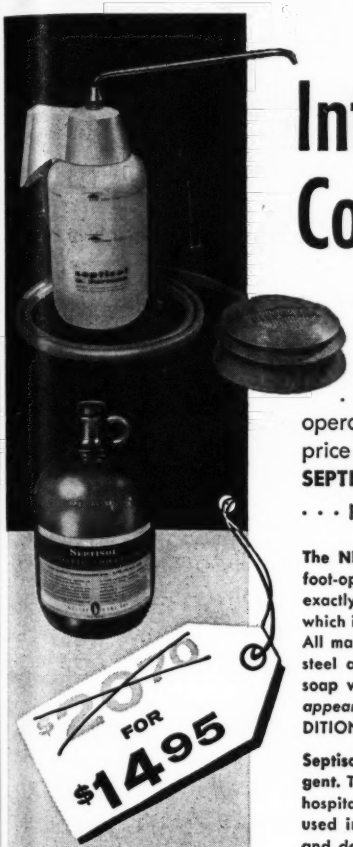
"As a fully qualified dental teacher, I had full charge of the first three years of dentistry. I had stressed the fact to the incoming students that each one of them must have Doctor Black's 'Dental Anatomy.' It was a dark, bluish-black book.

"I gave them 15 pages to study, and on my first test I issued the following questions:

(1) What is the color of your text book?

(2) Was the author a colored man or a white man?

March 1958. Monthly. Oral Hygiene, Inc., 1005 Liberty Ave., Pittsburgh, Pa. Subscription, $5.00 a year in U.S., Canada and Latin America; $5.75 elsewhere. Accepted as controlled circulation publication at Rutherford, New Jersey.



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(3) Draw or describe any diagram, or anything else you saw inside the book.

"It was not a surprise to me that 50 per cent failed the first question. Yellow, red, and green were the adopted colors.

"And 20 per cent failed the second, making a colored man of the subject.

"And 30 per cent failed the third, having no proof and admitting it.

"No one was penalized. I liked teaching dental students."

* * *

DOCTOR ABRAHAM PORTNOY of New Bedford, Massachusetts, thought of ORAL HYGIENE when a patient showed Doctor Portnoy a quaint old leaflet about dentistry. It had been printed long, long ago—nobody knows how long ago. It had been issued by H. T. Burpee, dentist, who was in practice at 151 Purchase Street in New Bedford, Massachusetts. The booklet's cover carries a woodcut, a sylvan scene including somebody's water wheel. But quite likely Doctor Burpee doesn't want patients hanging around the water wheel when there's a lot of quoting and unquoting that could be done, depicting the utter grandeur of Burpee's lovely fangs, for instance:

"Uppers can now be made to stay firmly in place in any mouth. Under sets stay firm, too, and do not rise up in eating or speaking."

Old Doc Burpee boasted of the best of facilities for extractions with the use of gas—even including the services of old Ma Burpee herself.

"A full set of teeth for $6--and upward. And our $9 set of Gum Teeth is the best material and finish. And no charge for extraction when Artificial Teeth are to be made."

Too bad space has been used up. We were just fixing to reveal "The Greatest Invention of the Age—the Burpee Process."

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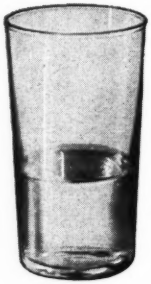
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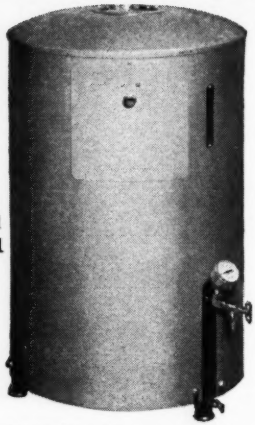
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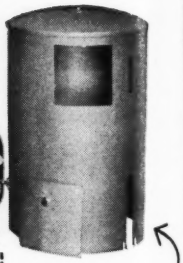
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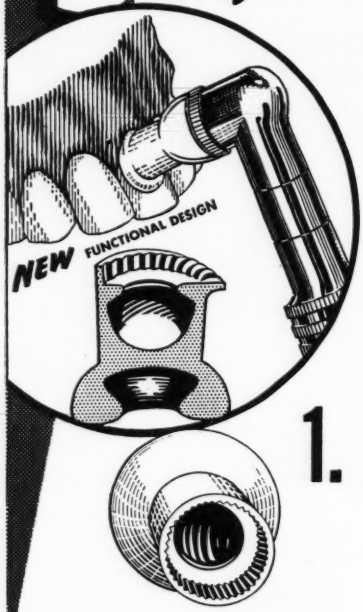
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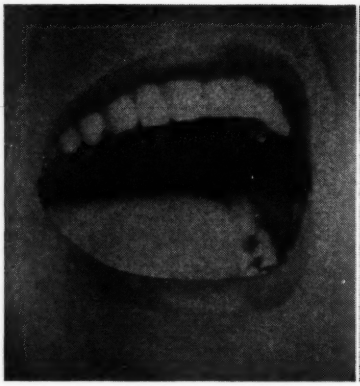
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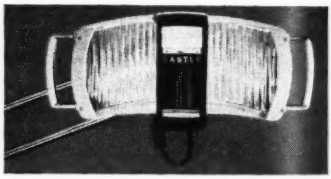
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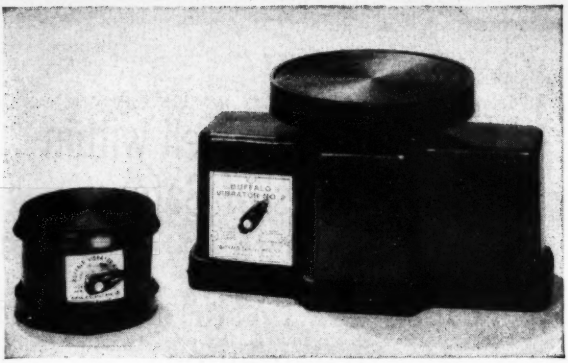
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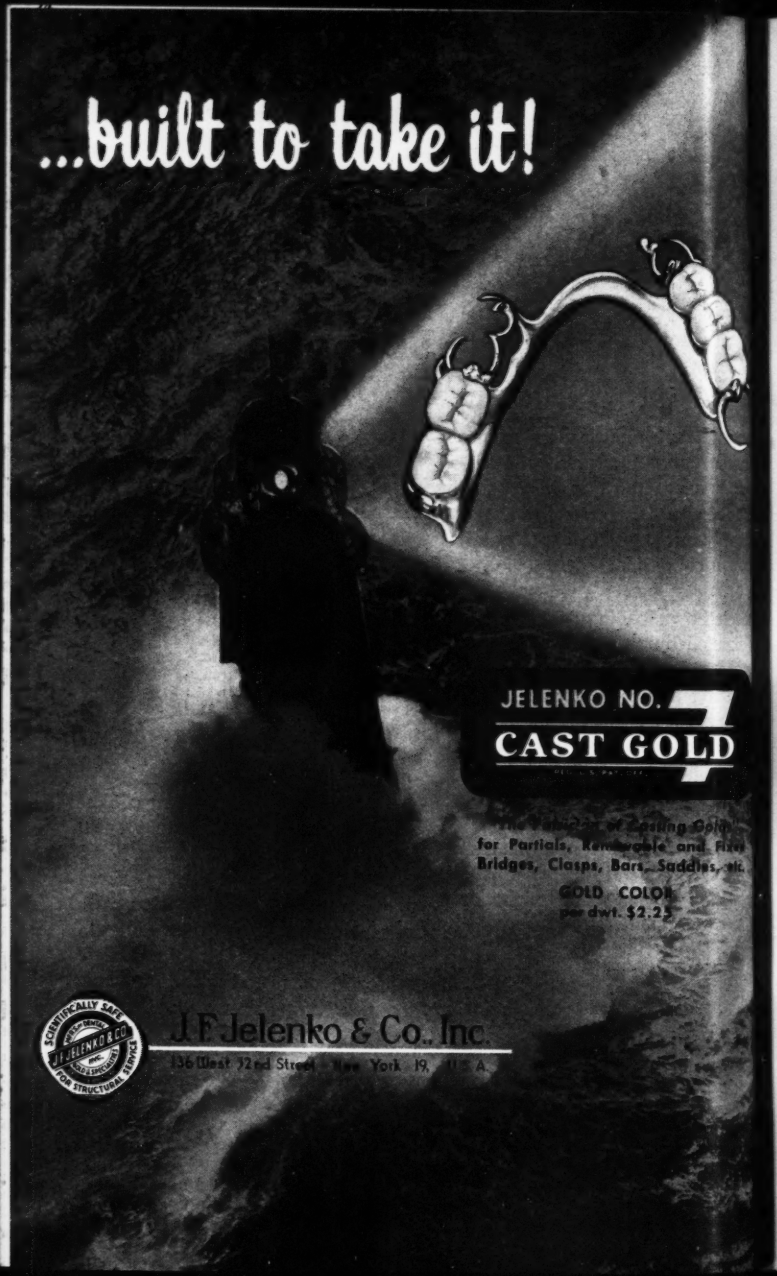


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MARCH 1958

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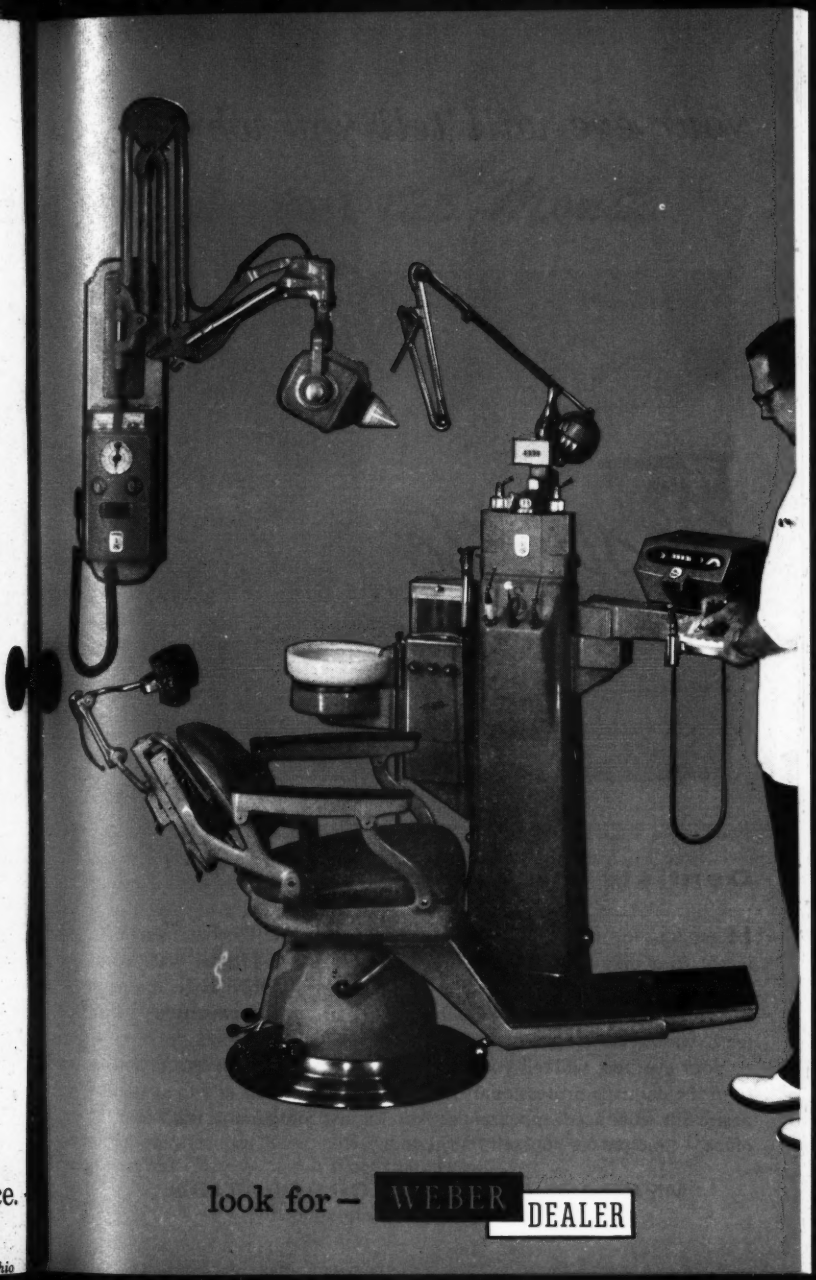
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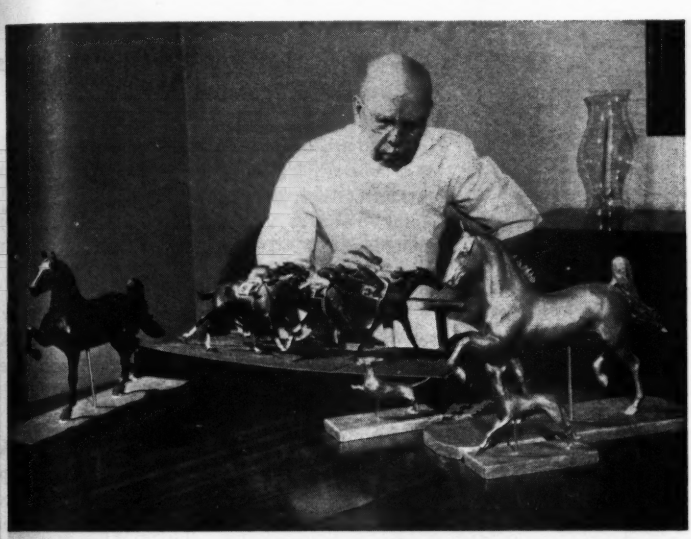
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Picture of the Month



WAUKEGAN, Illinois, dentist, Doctor Lockwood W. Yates, has enjoyed drawing horses since he was a boy. In later years he found he could use the leftover wax from his dental practice for sculpturing, and so his hobby was born. First Doctor Yates sketches the animal, then he builds a wire frame to help support the body structure. Next he molds the clay around it. When completed, he has it cast in bronze and finally colors it in oil four times to attain the appearance of a flesh and blood animal. Each of his models takes about six months to complete. The race horses mounted on a quarter-turf complete with jockey mounts are the results of hours spent at the track studying horses.—*Photograph courtesy of Waukegan News-Sun.*

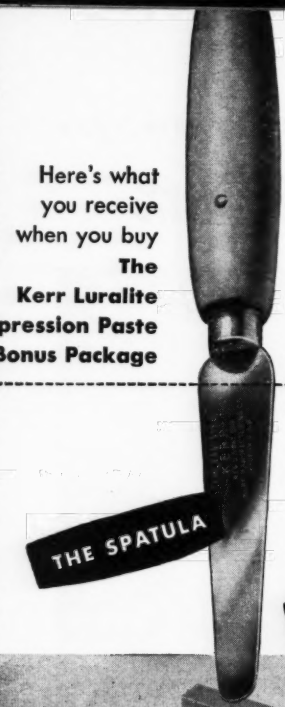
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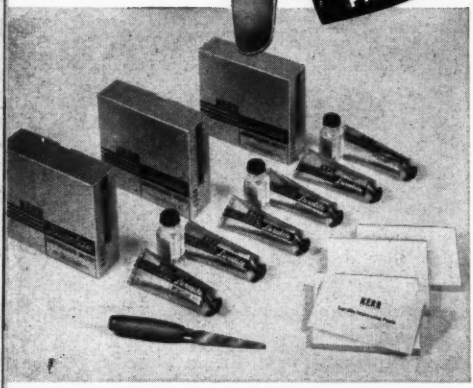
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Psychologic Preparation of the Denture Patient

BY MARTIN M. JACOBS, DDS*

A suggestion for eliminating some of your denture patients' complaints.

MANY times we have inserted a set of full upper and lower dentures in a patient's mouth with the feeling, "this is a job well done." The mouth presented no particular problems. The ridges were ample, muscle attachments normal, and everything looked favorable. The dentures were pleasing esthetically, the retention was good, the centric relation and vertical dimension seemed correct. Then the patient returns for his first adjustment.

"How are you getting along, Mr. Jones?" we say in our most cheerful tone. The ensuing list of complaints slightly startles us. I am sure most of us have had this experience. We all know that a patient should be prepared mentally before making a denture for him, but in the hustle of a busy practice we often pass over this phase too lightly. If mental conditioning is not accomplished *prior* to the time of insertion, it will have little or no effect. When a patient is made aware of the pitfalls and difficulties he may encounter *before they happen,* he will take to them more kindly and philosophically if and when they occur. If they do not—you are a genius.

As we all know, the biting force of a full denture is considerably less than that of the natural dentition. Most people are not aware of this fact unless it is specifically pointed out to them. A denture wearer is a dental cripple. He must expect to make some compromises. A prosthetic appliance is only a replacement for lost parts. All have their limitations. True, the present denture is a thing of beauty, but making the denture is only one phase of a successful res-

*Doctor Jacobs is a staff member of the Prosthetic Section, Sinai Hospital, Detroit, Michigan.

toration. The second phase is the patient's ability to learn to use the appliance. Some people are more proficient than others in doing this. Just as some people learn to drive a car better than others, so do some learn to master their dentures with greater ease and efficiency. That is why, for a happy denture practice, psychologic preparation, or mental conditioning, is of the utmost importance.

It is the satisfied, happy denture wearer that refers others to us for prosthesis, not the patient with the dentures which we think are excellent, but with which he is unhappy, for one reason or another.

Explanation Dispels Fear

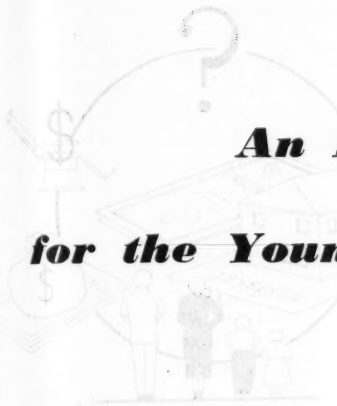
One of the most difficult denture patients is the apprehensive type. He will come in and say: "Doctor I know I'll never be able to wear plates." Upon questioning he will give such reasons as "I gag easily," "I can't stand anything in my mouth," or he will have a relative or friend who has had an unhappy experience with dentures. This negative attitude must be overcome before beginning any procedure, and can be done by a careful explanation to dispel undue fears. A word of caution—do not overdo it and promise more than you can fulfill.

In conclusion, the mental attitude of all prospective denture patients should be examined as carefully as the mouth. The success or failure of a case may well depend upon this. Some will have a totally defeatist attitude; others will expect too much from a denture. These are the two extremes. A middle-of-the-road feeling is most advantageous. It is our duty to bring the patient around to this way of thinking.

27825 *Gratiot Avenue*
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THE NEED FOR A GOOD DIET

CLINICIANS often relate diet to dental health only in terms of the obvious effects of deficiencies that can be noted by physical examination. Nutritional deficiencies may exist, however, and have deleterious effects on dental structures even though these effects may not be obvious in general clinical examination. It is possible that dietary factors may play an even more important role in malocclusion than the present limits of our scientific observations specify. It is, therefore, even more important to say that good diet is always necessary, not only for good occlusion, but also for strong bones, and caries-free teeth. A good diet is necessary to good health—throughout life—for all tissues of the body.—W. P. PHAIR, DDS, MPH, *Modern Nutrition, Los Angeles.*



An Estate Plan for the Younger Dentist

PART I

BY ALLAN J. PARKER, LLB, LLM*

This is the first of a two-part article giving suggestions for providing security for your family, and for a retirement fund.

In 1956 the Nation's dentists came under Social Security coverage for the first time. This new coverage promises a minimum floor of financial security for the dentist in his old age and the assurance of at least subsistence support for his family in the event of his untimely death. To date, however, Social Security is not a substitute for the individual's own sense of responsibility for furnishing financial security to his family by supplementing Social Security benefits in other ways. This whole new and developing field of protection for loved ones and for the individual in his old age is known as Estate Planning. It draws upon the skill of the attorney, the insurance underwriter, and, frequently, the trust officer of a bank and an investment counselor or broker.

Acknowledging that the one person who does not exist is the "average man," let us nevertheless take as our example a young, upcoming dentist—call him Doctor John White—about whom we assume the following facts:

Married—both he and his wife are 33 years of age.

Three children, aged 7, 3, and 1.

Income from practice—$15,000.

Life insurance—$10,000.

Residence (mortgage $15,000) $25,000.

*Mr. Parker is a member of the New York Bar.

Cash and Government Bonds—$2000.

Before there can be a plan, there must be an objective. Again it is assumed that Doctor White's principal objectives are (1) to furnish security for his widow in the event of his early death, and to see that his children are cared for and educated; (2) to provide for himself and his wife in their old age where no pension awaits him, as one does for so many corporate executives; (3) of perhaps lesser importance, to leave to his children some property to assist them after his death.

Protection of Earnings

The foremost consideration for obtaining Doctor White's first objective, security for his wife and children, almost inevitably brings up the subject of life insurance on his life. Planning for family security and leaving out life insurance is likely to wind up all plan and no security.

Social Security, of course, assuming full coverage, provides a substantial start on any insurance program. Assuming that the father is fully insured and has average earnings of at least $4200 per year, Social Security would provide his widow and children with an assured tax-free income of $200 per month until the second child reaches the age of 18; then however, payments drop to $162.80 per month till the third child reaches 18; then they stop. If she has not remarried, Doctor White's widow would later regain a widow's Social Security benefit, but only on reaching the age of 62.

The need for life insurance does not overlook the possibility that the mother could leave the children and go out and find a job; always assuming, of course, that she was not in the same car or airplane at the same time her husband lost his life. But even if we say that she could obtain a job paying a respectable $300 per month, there would be numerous deductions, such as taxes, commutation expenses, lunches, the cost of extra clothing, and the large item of someone to take care of the baby every day, perhaps reducing the net earnings to $150 per month. And that is not all. Since, as a widow, Mrs. White would be earning a gross salary in excess of $2080 per year, she would lose her Mother's Social Security Benefit of $81.40 per month. The children's benefits, however, would continue.

Thus, many family counsellors, who are not insurance agents, urge that some insurance protection is a basic necessity for promoting family security and happiness.

Life Insurance as Protection

On the question of how much and what kind of life insurance to buy, the services of a competent insurance agent or broker should be obtained. The insurance industry offers a wide range of policies for varying needs, complete discussion of which is beyond the scope of this article.

Briefly, however, the life insur-

ance policies ordinarily available are divided into two broad categories: term insurance, or life insurance as protection; and permanent whole life insurance, or life insurance as protection plus savings.

Term insurance is pure protection—like fire insurance. If your house burns down, the insurance pays you the value of the house. If the house does not burn down, your premiums have simply gone to pay the losses of those persons whose houses did burn down, together with paying overhead costs of the insurance plan, and there is no return to you. On term life insurance, the protection runs for a specific term, 5-10-20 years or longer; but at the end of that time, if there is no loss of life, there are no further values in the policy. On the other hand, if death does occur, this policy pays its full face value.

One primary function of term insurance is to furnish lower cost protection to the families of young fathers. Term insurance may be converted to another type of permanent insurance, a procedure which many life insurance men recommend.

Protection Plus Savings

Acquisition of term insurance furthers the first of Doctor White's primary estate objectives, protection of his family; but not the second, providing security for his and his wife's old age. Other policies are available for this purpose.

Ordinary life insurance is the best-known example of permanent, as opposed to term insurance, which combines with the element of pure protection an element of saving, whereby the insured builds up certain cash reserve values to his credit with the insurance company, something like money in the savings bank.

This reserve is not exactly like a savings account. Withdrawals are permitted only as interest-bearing loans, but they are available in all cases. The company has no discretion about making the loan. These values may be drawn upon during the father's life, either as an emergency fund, or the policy may be cashed in creating a retirement fund in the event that he does survive to the point where his children are self-supporting. The value of the policy may then be taken either in a lump sum, or as an annuity to pay to him a guaranteed monthly income as long as he lives. Or the cash reserve money might be used to help pay for a college education for his children.

Needless to say, this type of whole life policy, combining the insurance element of a term policy with a savings element, costs more than pure term insurance protection. However, it must be remembered that a large part of the difference in cost represents not so much an expenditure, as enforced savings.

Frequently, an experienced insurance agent or broker can offer an attractive means of combining

the two basic forms of insurance, permanent insurance and term insurance, into a plan which affords many of the advantages of both types through what is known as an ordinary life policy with a family income rider.

Life insurance companies offer additional types of insurance in which the savings element is still further increased, such as endowment insurance, or limited payment life. That is, by paying higher premiums, Doctor White would build up cash values for his own eventual retirement, at a more rapid rate. There can be no question that as a savings program insurance has a great deal to recommend it—particularly the semi-compulsory nature of the savings. A savings bank deposit may be skipped, "just this once," and experience of savings banks seems to bear this out; but insurance premiums somehow usually get paid.

Indeed, all of the savings which many men ever accumulate during their lives are in the form of insurance cash values, and perhaps a home.

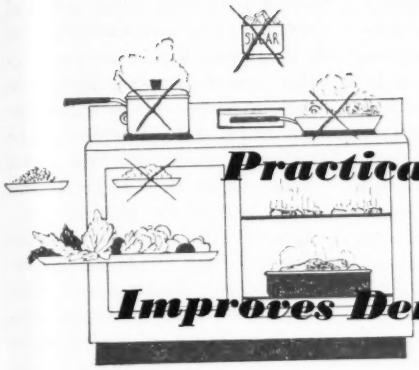
It will be seen in time that through a program of ordinary life insurance or other forms of savings Doctor John White can build for himself something nearly equivalent to his own pension plan. From a Federal income tax point of view, the increment in value arising from investment by the insurance company of his funds is not taxed to him nor to the insurance company, as insurance companies pay taxes at a much lower effective rate than other corporations. In other ways, however, the self-insured pension plan is different from a corporate executive's, and no real comparison can be made.

Before Doctor White's life insurance agent leaves, he will probably suggest to Doctor White the importance of his including in his insurance program a certain amount of disability income insurance, which may be obtained as an additional feature to most ordinary life insurance policies at extra cost. Disability insurance is particularly important for a self-employed professional man whose income ceases the moment he becomes unable to work—again as opposed to a corporate executive who, in many cases, may be carried by his corporation for months or even years of disabling illness at full salary.

120 *Broadway*
New York 5, *New York*

DENTAL CARE FOR AGED AND CHRONICALLY ILL STUDIED

A NEW four-year study designed to find ways of providing dental care for aged and chronically-ill persons unable to visit dentists' offices has been announced by the U. S. Public Health Service. Data on costs and methods will be collected. The Kansas City metropolitan area has been designated as the site of the study. This project supplements other research currently being supported by the Service in this field. —*Medical Science, Philadelphia.*



Practical Nutrition Improves Dental Health

BY N. R. CHAPIN, DDS

An explanation of the cause of dental disease and what can be done to develop healthy tissues.

NOW THAT national recognition has placed us with physicians as guardians of the public health, it is time for us to consider seriously more of the responsibilities of this trust. There has to be a reason why, so many restorations are needed, so much calculus forms, so many teeth are lost prematurely, so many edentulous ridges are tender and continually receding. We must do more than repair these damages mechanically. If we are to live up to the title, "guardians of the public health," we must educate patients so they may guard against these troubles.

There is only one basic idea: Sound robust health, dental or otherwise, results from complete nutrition. The framework of a building put up with too few nails is a weak structure. Concrete mixed with too little cement in proportion to the other ingredients cannot be expected to have acceptable strength. Teeth, gingivae, ridges, or any human tissue that has to be produced from a diet lacking in some essential ingredients are not strong, disease resistant, and enduring.

The conflicting tips and suggestions about nutrition that the public receives from all sides these days are extremely confusing. We should help our patients to understand *why* complete nutrition is the basis of all good health. Point out that dental health can be a guide to their general well-being. The results of nutritional defici-

encies that cause dental disease are seen easily in the mouth. This is a direct clue to what may be happening to other vital organs, glands, or tissues that cannot be seen. It offers a dramatic and forceful illustration of interest to any intelligent person.

Parents should know the significance of the constituents of foods: That some of these contents, as well as vitamins and minerals, are perishable ingredients, but that they play a most important part in the complicated process of digestion and assimilation; that without them many of these necessary actions cannot occur properly.

Foods must furnish all the needed building materials that a growing child must have. When good materials are not furnished, or substitutions of poor quality are made, the results are obvious. These facts will illustrate the importance of natural fresh raw foods. It is the refining, processing, preserving, treating, and too often improper preparation and cooking methods at home that can destroy these important and perishable elements.

Refined Sugar

Patients should know the facts about refined white sugar. Not one person in one hundred knows that the normal process of digestion converts at least 60 per cent of all food eaten into body energizing sugar. Refined raw sugar may therefore all be in actual excess of need, except in rare cases. Neither do they know that a normal glandular process secretes insulin to insure a proper blood sugar balance, and that this function can be overtaxed seriously. The direct damage sugar does in the mouth is only part of the picture.

Grains are an important source of much of the world's food supply. Modern refining processes remove a long list of the most valuable ingredients from good whole grain wheat. Enriched and bleached white flour replaces only a fraction of what was removed. Polished white rice is similarly depleted.

It is well known that our United States diet contains an excess of fats. Even many of our valuable vegetable oils have been hydrogenated.

Pastries containing fats, white flour, and sugar, have little to ecommend them as health builders.

Mashed potatoes, one of our most popular and standard foods, is a good illustration of our thoughtless destruction of good food elements in our own kitchens. Peeling removes the mineral-laden skin to be discarded. Boiling dissolves out the water-soluble vitamins and minerals, which are poured down the drain. The discarded items can be of as much or more value than remains to be eaten. This can also be true of any food that is boiled when the dis-

solved nutrients are drained off.

We can point out that broiling is far superior to frying when cooking meats, our best source of protein. This is also true of sea foods, which in addition are a reliable source of minerals, since the sea is a great storehouse of all minerals.

It should be remembered: That drinking quantities of milk does not necessarily guarantee good dental health; the fact that pregnancy is the only way to activate the mammary glands indicates that nature intends milk as an infant food; that while food supplements are helpful, the mere taking of a few drugstore vitamins does not correct for a constantly improper choice of foods and destructive cooking methods.

Although our treatment, selection, and cooking methods can destroy many of the perishable important food elements, the calories still remain. Hunger, Nature's call for nutrition, can cause habitual overeating when much of the food eaten contains only a fraction of the nutrition needed.

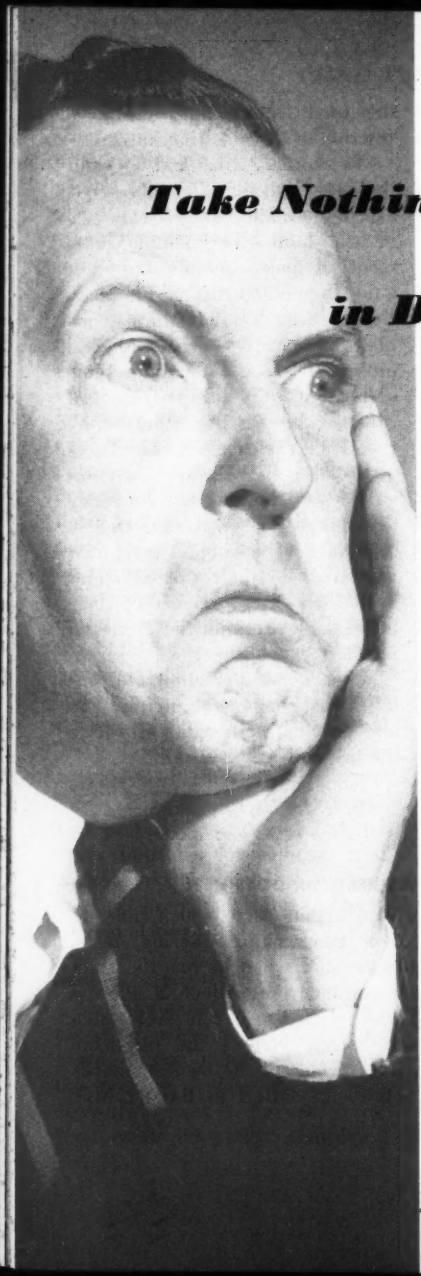
We should realize and consider the fact that all living creatures, except human beings, eat raw natural foods. This simple statement of fact contains our best guide to good nutritional practices. Use more fresh, raw, natural foods in preference to processed and preserved ones. Substitute nuts and fresh fruits for pastries. Eat raw salads. Discover that many vegetables are excellent raw. These raw foods satisfy the appetite more quickly so there is less tendency to overeat. Those persons unable to manage the roughage of raw vegetables in their diet can still avail themselves of most of their benefits by drinking the extracted juices.

While helping to eliminate dental disease, complete nutrition can also provide the benefits of a long life of good general health.

1224 *Manatee Avenue*
Bradenton, Florida

YOUR PHYSICIAN KNOWS BEST! OR DOES HE?

EVERY physician has a set of fairly firm beliefs as to which illnesses are acceptable and which are not; how much pain, suffering, fears, and deprivations a patient should tolerate, and when he has the right to ask for help or relief; how much nuisance the patient is allowed to make of himself, and to whom. These beliefs are hardly ever stated explicitly, but are nevertheless strong. They compel the physician to do his best to convert all his patients to accept his own standards and to be ill and to get well according to them.—MICHAEL BALINT, MD, *Lancet, London.*



Take Nothing for Granted in Dental Practice

BY CHARLES L. MEISTROFF, DDS

EVERYONE of us go through our paces with each individual patient the same way—pick up a mirror and the mouth opens reflexly. You look about, reflexly choose an explorer, and start probing. Possibly, you grasp a prepared syringe in one hand, and with the other you start palpating for the retromolar triangle. You lay down a cavity preparation instrument, and reach for an air or water syringe. These reflex motions are second nature—a pattern of actions triggered by previous experience in a sort of chain reaction cycle. All of these things and many more we do unconsciously in our efforts to practice dentistry.

I have in mind the many minor and some major things which definitely fly back at us several months or even later. It is too late then to improvise a rehabilitative measure—it must be done over. I refer to the little things that take only a few seconds, or several

Short-cuts may result in embarrassment and loss of good will.

never-to-be-missed minutes; and yet they save you time, unnecessary work, aggravation, and patient doubt.

You recall the particular Mrs. Jones who came to you all in a dither. Doctor X had removed all her teeth, but due to some misunderstanding she would have to wait for several months before dentures could be started. But Mrs. Jones is a buyer in a large department store—she cannot go about her work minus teeth. She cannot face her public, nor can she undertake her out-of-town tours without teeth. She has been edentulous for about two weeks and is *simmering*. Someone mentioned your name and immediately your prosthetic stock hit a new high. She sees you, and actually demands full upper and lower dentures. Here is the line of thought to which I have reference. *You take for granted* that Doctor X has x-rayed her mouth prior to extraction, that no roots are retained, no alveolar debris present, no third molars remaining. You notice a large tuberosity and a knotty lower anterior labial plate. Begin to catch on? You take impressions, try-ins, and the final dentures are seated. For a few weeks you cheerfully adjust here, trim down a little there, grind this high spot, and generously give her of your abundant supply of denture adhesive powder—then the skies become black!

Three small spots are continually festering. Thus the tuberosity is always painful, and the anterior labial plate has a rough surface and hurts. It would have taken a moment to x-ray, and trim off the labial plate. The tuberosity you find is not a tuberosity at all, but an impacted third molar. Regarding the festering spots, two of them are fistulating, retained chronic granulomata, and the third one is a part of a crown with a piece of amalgam in it. If she were willing to come to you in the first place because of your prosthetic virtues, you muffed a chance to really give yourself a shine. You should have let her know of the preliminary survey and inquiry as to previous roentgenology, and of clearing up the obvious obstacles to a good prosthetic foundation. Your halo is getting tarnished; you have to admit something and start from scratch to retain good will.

Then there is the traveling salesman who could see you only on Saturdays at 12:30. You did two extractions and let him out as quickly as you could for that fishing jaunt down the river, as the boys were getting restless waiting for you at the parking lot near the office. You were impatient. Ordinarily you would snip off the sharp process, give some postextraction

instruction, and a prescription; but in this one instance you had to hurry. Now he has been back for three Saturdays in a row after getting you out of bed at 3:30 AM the week later; he also is getting three free treatments for dry socket, free alveolectomy, and a good deal of courtesy for good will.

Then there was another little chicken that grew up and winged its way home. Remember Mrs. I Q, the one for whom you made that beautiful lower partial denture, a work of art indeed; but you were leaving for your vacation in a few days and you were rushed. So instead of taking a few hours more and making an inlay for the first molar you saved (?) time by making an amalgam instead. Oh, it was a honey all right. Black's preparation, copper cement base, anatomical carving, and an engineered recess for the occlusal rest. It fitted perfectly, and then in about four months it happened. One side would not stay put; you checked and rechecked the occlusion. Then one day as you helplessly put the denture back in place you noticed that the hard casting had actually ground out a depression in the amalgam, and since there was no longer any accuracy in the rest-occlusal surface relation it was out of balance.

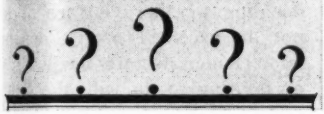
There is another one that long rankles in your memory; the day Dave Jones came in to have eight silicates placed in those upper anteriors. You had harped at him for over six months to have something done. He kept stalling like all the rest, and finally when he did come in it was a surprise and you with your bags ready for the cab to pick up. You wanted to be sure to get that plane about three hours ahead of time. But he wanted those teeth restored, and said it was a cash deal—and you could use that extra change. You took no x-ray pictures, and used local anesthesia because he was so nervous in the chair. You surely made time that day and set some sort of a record. You were gone for only two days, but when you returned he was waiting for you on the front doorstep of your home with four dying pulps and the rest ready to be buried.

Then for the last fling—the loose lower right central that was ready to sneeze itself out. No x-rays, it was so loose you just sprayed some ethyl chloride and the tooth came out all right, but left a fish-hook apex with a ball and socket end in the alveolus. You had to give local anesthesia, take an x-ray anyway, and it took you almost an hour to get the darned thing out. You were solicitous all the while you were working and sweating; he had nothing to say, but you could read his eyes.

Well enough said for now—hope I have sent something home.

10 *East Franklin Street*
Richmond, Virgina

So You Know Something About DENTISTRY!



BY ROLLAND C. BILLETER, DDS

CLXII

1. Calcium hydroxide is (a) superior, (b) inferior, to zinc oxide in pulp capping or pulpotomy. _____

2. In complete denture prosthesis, why is a malocclusion undesirable? _____

3. A coolant (a) is, (b) is not, advisable when using increased speeds for cavity preparation. _____

4. True or false? There is no absolute contraindication to any dental procedure for the patient with coronary sclerosis, but precautions should be observed. _____

5. Regeneration of structure following damage to the periodontium is (a) seldom, (b) frequently, obtained when the gingival crevice is involved. _____

6. Is a considerable amount of conclusive evidence available to substantiate the belief that leukoplakia is a precancerous lesion? _____

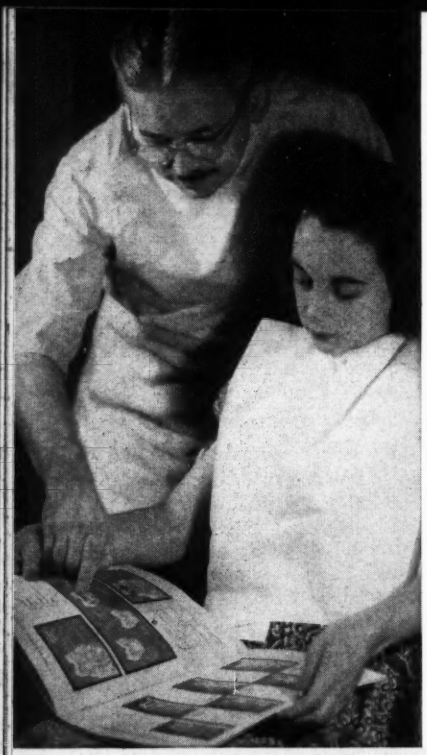
7. All authorities agree that traumatism (a) is, (b) is not, a contributing factor in periodontal disease. _____

8. Is mesial drift in the deciduous denture common? _____

9. True or false? Air bubbles in the investment are likely to collect on the wax pattern. _____

10. As a general rule, should three-quarter veneers in the posterior portion of the mouth cover the entire occlusal surface? _____

FOR CORRECT ANSWERS SEE PAGES 80, 82



Successful Strategies in Patient Management

BY CHARLES L. LAPP, PhD*

ASK YOURSELF this question, "What makes for your success as a Doctor of Dental Surgery?" from the point of view of the dental patient. Most patients are not capable of judging your diagnostic acumen or operative skill. Unfortunately, their primary means of deciding whether you are or are not an excellent dentist depends upon fringe factors having little or nothing to do with the dental service received.

Again and again professors in dental schools have stated, "Perform good dental service and the fee will be taken care of." This is in a real sense quite true—if the statement were broadened somewhat to, "Satisfy the patient's conscious and unconscious wants and likes, and avoid antagonizing patients, and the fee will be taken care of."

Ask yourself still another question, "Do I really want my patients to be satisfied with the dentistry I do for them?" Few dentists would say to this question, "I don't care!" In fact most dentists want to feel that a patient is satis-

*Doctor Lapp is a Professor of Marketing at Washington University, St. Louis and Management Consultant, as well as author of the book SUCCESSFUL SELLING STRATEGIES, McGraw Hill Book Company, New York; and PERSONAL SUPERVISION OF SALESMEN, Business Book Company, St. Louis, Missouri, 1957.

A definite plan of action suggested for gaining the confidence and loyalty of your patients.

fied and committed to them for their dentistry. If you want loyal patients, who will come back again and again, who are cooperative patients, and who will refer other patients to you, then you must give attention to your role in securing your patients' trust in you. Look at it from the angle of time and energy expended. At least eighty or more per cent of your thought and energy should be devoted to assuring that the dentistry you perform is of the highest quality. However, some ten per cent of your time and energy must be devoted to figuring out how to impress the patient with the quality of your dentistry.

Also, some ten per cent of your time and energy (even though you have auxiliary assistance) must be spent in making certain that the business aspects of your practice are in order.

Now to turn to some important successful strategies in patient management:

Successful Strategy No. 1—Greet Each Patient Warmly as an Individual. Speak to each patient somewhat formally, but not with coldness or indifference. It is not only what you say, but how you say it. A pleasant smile (not a grin) will overcome many salutations that otherwise might be ineffective. With adult patients you might find such a greeting as, "Good Morning, Mrs. Bedford," or "Good Afternoon, Mr. Carlson," most effective and least dangerous. (However in the case of a woman do make sure whether it is Miss or Mrs.). Avoid forcing a first name relationship unless you feel the patient wants it that way and you really feel on a first-name basis. If you are a pedodontist or accept children in your practice, you'll probably find children may react better to a simple greeting, such as, "Hello Karen." Avoid suggesting fear, or that the appointment is going to be an ordeal by such statements as:

"You don't have anything to fear this time."

"You look scared to death."

"It wasn't so bad last time, was it?"

"I'm not going to hurt you much this time!"

"How do you feel?"

Consider the statement, "I am certainly glad to see you here!" This might be interpreted by a patient as meaning, "Yeah! he must enjoy seeing me go through misery," or "Yes! he is happy to see me here to get some more of my money." Familiar greetings such as "Hello, honey," or "Hello, sweetheart," are typically out of place for a professional man. Your greeting and approach has an important prolonged effect on your longer relationship with a patient.

Remember, the patient in those few seconds after entering is sizing you up. Are you making certain the patient is formulating the size-up you want?

Successful Strategy No. 2—Allay Any And All Fears Of A Patient. Patients come to you often with certain fears—some of which may be justified and others may not be. Whether justifiable or not, such fears must be allayed, if not completely banished. What fears should you watch for? Some of the more common of course have to do with a fear of how painful their dentistry may be. Other fears build up because of not knowing what to expect with reference to:

(1) How long the dental service will require.

(2) How long they will have to wait for an appointment.

(3) How much the service will cost.

(4) How many teeth, if any, will they lose.

(5) How the dentistry may change their appearance.

The major step in banishing a patient's fears is to recognize that such fears exist, and then to have a desire to assist the patient in banishing any and all of them.

Successful Strategy No. 3—*Get to Know the Person Who is to be Your Patient.* A patient does not like to feel that he is just a mouth full of teeth, a street address, or a number. A patient likes to feel that he is an individual that his dentist understands. Taking a health history of a patient gives you an excellent opportunity to get to know the patient as a person. When you are trying to get to know a patient three strategies should be remembered. *One,* ask the patient questions which cannot be answered by "Yes" or "No." *Two,* when the patient is talking listen intently for clues to the person's personality. *Three,* observe carefully the patient's reaction to what you say.

It is extremely important to get to know each individual patient in order that you will have some idea how to deal with the patient. As you study your patients you will find you have many different types, which have to be dealt with quite differently.[1] Some patients may feel they know all about dentistry and will presumptiously attempt to tell you what to do and what not to do. With this type of patient you must follow a course of "shrinking his or her head" politely, but firmly. Some patients may be extremely narrow minded and lack knowledge as to the benefits of good dentistry. With this type of patient your course of action must be one of broadening his or her horizon, in order that the benefits of dentistry can be fully appreciated. Still other patients will think you are a good dentist, and accept your proposal, mainly because you are willing to talk to them about their favorite subject. In your initial appointment you may be able to detect the patient who is going to

[1]Lapp, C. L.: How to Handle Different Types of Patients, ORAL HYGIENE **47**:37, 48 (October, November) 1957.

take advantage of you in a number of ways, such as not paying his bill, failing to show up for appointments on time, or criticizing you to other patients and prospective patients. Some patients you may find can be "dubbed" none other than "cry-babies" and must be dealt with accordingly. Remember, patients are different and therefore cannot all be treated the same, but each by their own standard (not yours) expects to be treated fairly.

Successful Strategy No. 4—Quote Your Fee So There Can Be No Misunderstanding. Many patients feel dentists are too evasive about quoting their fee when asked for it. The patient who wants to know will have a fee in his own mind that is either higher or lower than the one you might quote. If the patient has a higher one in mind, then it may deter the patient from proceeding with needed dental service. If the patient has a lower fee in mind and then proceeds when he gets your statement the reaction will be, "I've been robbed!" Misunderstandings can develop from quoting the fee as "about so much." If you want patients to accept your fee structure, then quote your fees as if you feel they are reasonable. Any doubt in your own mind is projected easily and silently to the patient.

Successful Strategy No. 5—Use Varied Techniques For Handling Objections. The following formula might be used for meeting patient objections effectively:

(1) Anticipate objections that each patient may pose.
(2) Forestall or block an objection before the patient vocalizes.
(3) Listen intently to a patient's objection.
(4) Determine if a stated objection by a patient is real or just an excuse.
(5) Restate real objections.
(6) Determine for each objection whether it is better to handle it by asking the patient why the objection has been made, agreeing with the patient, agreeing but showing there might be another point of view, turning an objection into an advantage or benefit to the patient, denying the objection, giving third-party testimonials as an answer, using assurance phrases, or ignoring and going on to some other phase of your case presentation.
(7) Concentrate on the values and benefit of your service, particularly if the patient objects to your fee.

Successful Strategy No. 6—Ask Each Patient For a Commitment. Too frequently I am afraid some dentists diagnose a patient's problems and make a case presentation, but fail to get a pay-off or a sufficient pay-off because they fail to get a commitment from the patient. Unfortunately, two-thirds, three-fourths, or even seven-eighths of a commitment do not pay off. You must assist and make it easy for patients to accept optimum dentistry. *First,* and most important, you take the attitude they are going to say, "Yes," and you will be

surprised how many more patients do. *Second*, get a commitment from the patient by using a number of techniques, such as:

(1) Assuming they are going ahead with your service, and it is just a question of setting up the first appointment time.

(2) Building a series of acceptances, which makes it easier for the patient to agree to the final commitment.

(3) Focusing attention on the benefit the patient wants most from the suggested dental service.

(4) Giving the patient a choice as to type of treatment or time of appointments.

(5) Summarizing the advantages of the complete service you are proposing.

(6) Bringing in an impending event or an additional benefit that will appeal to the patient to act now.

In conclusion, if you will give just a little time, thought, and energy to how you can more successfully handle each patient, you will be surprised how much more you will enjoy your practice and, incidentally, how much more money you will make.

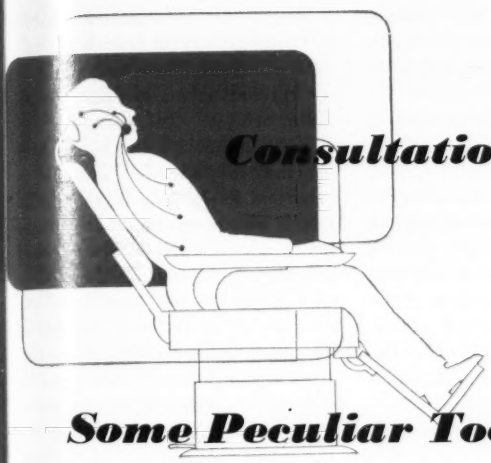
Washington University
St. Louis 5, Missouri

ORAL MALIGNANCY

ONE WOULD imagine that a patient with oral malignancy would have a greater chance of prompt diagnosis than would a patient with malignancy elsewhere in his body. The unpleasant truth is that the patient with oral malignancy fares less well than do patients with other types of malignancy. The patient with oral malignancy probably fares so poorly because the oral cavity is essentially a "No Man's Land." Many dentists, indeed the vast majority of them, restrict their observations to the teeth and the gingivae. As for the medical practitioner, the oral cavity is of secondary interest, and I am loath to say that too often it is regarded merely as a cavity through which one must peer to observe the tonsils.—S. GORDON CASTIGLIANA, MD, *Massachusetts Dental Society Journal.*

"SLEEP THAT KNITS UP THE RAVELED SLEEVE . . ."

IN RESPONDING to a questionnaire on how much sleep they needed to restore full mental and physical capacity, 150 distinguished citizens answered as follows: five hours, 2.5 per cent; six hours, 6 per cent; seven hours, 15 per cent; eight hours, 65.5 per cent; nine hours, 9 per cent; ten hours, 2 per cent.—*Medical Science*, November 25, 1957.



Consultation Clinic:

Some Peculiar Toothaches

BY ARTHUR ELFENBAUM, BA, DDS*

You must be able to recognize a toothache that is caused by a systemic disease in order to maintain your status as a professional man.

IRRESPECTIVE of its cause or character, a toothache is rarely welcome in the dental office. The patient usually expects immediate attention, and if the dentist is obligated to serve him, the office schedule is generally upset. If the patient is a stranger and the dentist feels that it is not his legal or moral duty to accept him, the victim may have to wander from one office to another. "For there was never yet philosopher," said Shakespeare, "that could endure the toothache patiently."

If the aching tooth can be identified without consuming an excessive amount of time, the diagnosis and treatment are not too much of a problem. One look may be enough to place the blame on an exposed pulp, a lateral abscess, a fractured crown, or any one of the myriad dental and periodontal causes. An abnormal image in the roentgenogram may give the dentist further insight into the etiology. The patient himself may actually be able to put his finger on

*Doctor Elfenbaum is Professor Emeritus, of the University of Illinois and Northwestern University; and Consultant in Diagnosis at the Dental Training Center of the West Side Veterans Administration Hospital, and the Dental Department of Michael Reese Hospital, Chicago.

the painful member. His account of the onset, duration, character, remission, exacerbation, and other subjective factors may enable the dentist to interpret the symptoms and arrive at a diagnosis. When a patient has a low pain threshold, is highly upset emotionally, or heavily sedated, the subjective symptoms are sometimes difficult to interpret. A child's account may not be easy to rationalize. A severely ill patient cannot always express himself adequately. Frequently a pulp is in an extremely active hyperemic condition due to trauma, or it is severely irritated chemically by cement or acrylic material, or thermally by the extreme proximity of a metallic restoration. There may be no evidence of disease from the clinical examination of the tooth. An x-ray examination may likewise be negative in every respect. Although the pain is severe, there is a possibility that the pulpal condition is reversible.

The pulp appears to have a definite defense mechanism which is not fully understood as yet. The odontoblasts may form secondary dentine, or calcifications may occur to ward off the irritant. If the pulp loses the battle, it may die without further pain being experienced, but when it becomes necrotic, the inflammatory exudate when forced through the foramen, may initiate a toothache which is really a bone ache. Eventually the trabeculations in the bone break down, the debris is carried off, and the roentgenogram reveals a characteristic radiolucent area which is interpreted as an abscess, granuloma, or cyst.

The toothaches mentioned thus far may be included in what is regarded as routine in the dental office. However, there are toothaches which warrant being called peculiar, inasmuch as they occur in clinically sound teeth and are caused by a systemic condition. The teeth have no anomalous formation, no defect in structure, no lesions, no restorations, no periodontal pathology, no occlusal disturbance, no history of trauma, and no previous symptoms. The roentgenogram can be expected to be negative. This concept of a toothache in a clinically sound tooth without a related local cause is somewhat strange in clinical dentistry, but it is worthy of serious consideration.

Oral-Systemic Correlation

Whether or not the dentist needs to know about systemically caused odontalgias for the purpose of making a living, his status as a doctor, dedicated to the art of healing, will suffer a serious setback if a patient with such a toothache consults him and he has to confess that he can see no possible cause. Where but to a dentist is a patient expected to go if he has a toothache? He does not have the slightest inkling that the pain in his tooth is induced by a sys-

temic cause. He may know that he has a physical or psychologic condition and he may be under medical care for it, but it is hardly possible for him to realize that there is an oral-systemic correlation. Even if he suspected it and spoke to his physician about it, he would no doubt be referred to the dentist for relief.

One of the commonest systemic pathologies often responsible for a toothache is an acute maxillary sinusitis. The referred pain may be manifested in clinically sound maxillary teeth, and the patient may indicate one particular tooth that hurts. Intraoral roentgenograms may present no evidence of periapical disease, and the electric pulp tester may give a normal or slightly accelerated positive response. There may be a tenderness to percussion. Clicking the teeth of both jaws together may give what patients sometimes call a wooden feeling. The pain in the tooth is caused by an irritation of one of the branches of the superior alveolar nerve which stems from the maxillary division of the fifth cranial nerve. The inflammatory condition in the sinus and in the bone which contains the nerve affects it adversely.

Similarly, a benign or malignant neoplastic growth in the sinus or a cerebral tumor may be discovered from the diagnosis of a toothache. It occasionally happens that an odontalgia is the prodromal symptom of a herpes zoster, which affects the second or third division of the trigeminal nerve, and the patient consults a dentist before the lesions appear on the face. The danger confronting the dentist lies in his being misled when the patient definitely locates the pain in a tooth, and a needless extraction or pulp removal is performed. Every dentist should familiarize himself with the rudiments of the diagnosis of the systemic pathologies mentioned here, not with the idea of knowing what to do for them, but for the purpose of understanding what not to do.

Angina Pectoris

Before an attack of angina pectoris, a patient frequently experiences an aura, a warning sensation which precedes the substernal paroxysm. He notices a discomfort along the left shoulder and arm with a tingling feeling in the fingers of the left hand. Cases have been reported in which the aura is accompanied by pain in the left mandibular molars, although the anatomical relation is not clear. The toothache may be the first symptom; a visit to the dentist follows, but if the anginal attack occurs while the patient is in the dental chair, the experience can be a harrowing one for both patient and dentist. These patients generally carry nitroglycerin with them, and the dentist should immediately urge the patient to place a tablet under his tongue to effect a rapid vasodilatation. A small al-

coholic drink also helps dilate the spasm in the blood vessel walls.

In any physical condition which is accompanied by a hyperemia, the vascular walls are stretched by the increased volume of blood. As part of the generalized hyperemia, a congestion may appear in the pulp canals of the teeth. An abnormal amount of pressure is built up within the confining, hard and nonresilient walls of the comparatively small compartment. The lymphatics and the semi-fluid connective tissue material add to the overcrowded mass. The minute apical foramen is too small to permit free exit of the venous blood and other fluid contents of the canal. The congestion may not be enough to cause strangulation of the pulp (a common occurrence in acute pulpitis), but the pressure on the free bare endings of the pulpal nerve is translated into a pain sensation. Furthermore, there is a possibility that there are nerves within the blood vessel walls to regulate their contraction and dilatation, and if so, they too suffer from the pressure and take part in the pain mechanism. This type of toothache may occur in one or more teeth. It was once referred to as a pseudopulpitis, but the word is no longer used, since the process is definitely not a false one. The innervation of the dental pulp has long been a controversial subject among the histopathologists, but nobody denies that the hyperemia within a pulp canal does cause severe pain and its management in the dental office is a difficult one.

The type of toothache just described often occurs during the few days before the menstrual period begins, and is part of the syndrome known as premenstrual stress. The odontalgia is relieved when the menorrhea begins and the hyperemia abates. Pain in a clinically sound tooth may be explained on the same basis in hypertension and alcoholism. The dilatation of the pulpal blood vessels causes a toothache, just as the vascular stretching in the cranium gives rise to a headache. By the same token, the edema which usually occurs in pregnancy, especially when toxemia is present, may extend into the pulp canal and induce a considerable amount of pressure pain. The rise in blood pressure initiated by intra-uterine pressure may also be a factor.

Bacteremia

Bacteria are known to invade the body. They may remain in situ and become innocuous, but when the body defenses break down and the organisms are transported by the blood stream to areas which are especially sensitive, a disease process occurs. Such a bacteremia may be introduced into the pulp canal of an apparently healthy tooth and be manifested as a toothache. The reversibility of the pathology depends on the improvement in the patient's health which sometimes

happens spontaneously and the toothache is relieved.

A similar transference of a systemic pathology by the hematogenous route may be found in leukemia. The leukocytes undergo a wild mitotic cell division in their immature state, for which reason leukemia has been called cancer of the blood. The overproduction may cause the interdental papillae of the gingivae to bulge, giving the dentist the opportunity of being the first one to detect the disease. When the immature leukocytes crowd into the pulp canal, the tremendous pressure within the hard and unyielding walls can cause a toothache and destroy the vitality of the the pulp. Necrotic pulps in such teeth have been described by histologists as having pulpal abscesses.

Patients with tabes dorsalis often complain of toothache without any apparent reason, but since neurosyphilitic lesions are common in these patients, it should be no surprise to find that the pulpal nerves are involved. Moreover, syphilis being a mimetic disease, it may simulate a toothache as well as any other discomfort. Changes in the pulpal tissue of tabetic patients have been observed under the microscope, and they resemble the degenerations found in nerve tissue in any other part of the body.

When the occluding surfaces of the teeth are severely ground down in bruxism, enough to approximate the vital pulp, the patient may complain of toothache, especially when secondary dentine does not form. It is generally conceded that bruxism, called bruxomania by some, is the manifestation of a psychologic imbalance, and should be included among the systemic diseases. Other psychogenic toothaches are receiving more serious consideration as psychosomatic dentistry is being better understood.

431 *Oakdale Avenue*
Chicago 14, *Illinois*

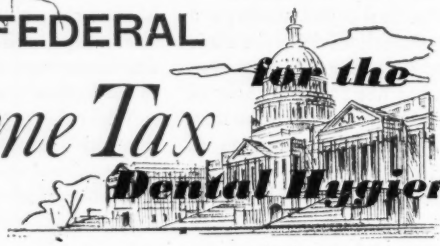
THE COVER

THIS MONTH'S cover photograph of the Tyler-Davidson Fountain in the heart of downtown Cincinnati, called Fountain Square, with the Carew Tower and the Netherland Hilton Hotel in the background, represents an invitation to the Annual March Clinic Meeting of the Cincinnati Dental Society to be held March 23 to 25. For reservations and information about the meeting, please write to H. Fred Lee, DDS, 3180 Harrison Avenue, Cincinnati, Ohio.—*Photograph courtesy of George E. Cramerding, Publicity Director, Cincinnati Chamber of Commerce.*



YOUR FEDERAL *Income Tax*

Tax Pointers for the Dental Hygienist and Assistant



BY JOSEPH ARKIN, CPA*

THAT TIME of the year is here again when your employees are faced with the filing of federal income tax form 1040. Practicing dentists can perform a service that strengthens the employer-employee relationship by calling to the attention of their assistants the information contained in this article.

An assistant or hygienist, being an employee, is required to report wages earned, on page one of the tax return. Other income earned is to be reported on page three of the return, and the total then brought forward to page one. The total of these figures, less any amounts which by law are deductible on page one (see instruction booklet accompanying return) constitute the "adjusted gross income." If the total of this "adjusted gross income" is under $5000, two methods of computing the tax can be used. The tax table can be used, or if itemized deductions for interest, charity, casualty losses, taxes, and job expenses, exceed 10 per cent of the adjusted gross income figure, then it will be to the taxpayer's advantage to itemize deductions on page two and compute the tax on what is commonly called, the "long-form."

Where the adjusted gross income exceeds $5000, the tax is computed by deducting the itemized deductions on page two, or

*Mr. Arkin, BBA, CPA, is licensed by the State of New York, and is admitted to practice before the Treasury Department.

You may pass along this information from a tax expert to help your assistant in preparing her income tax return.

taking 10 per cent as a standard deduction. The standard deduction is limited to $1000.

Possible Deductions

What deductions can be taken on the return of the hygienist or assistant? Both can deduct for the cost of books purchased in connection with employment (only if of short useful life, otherwise the cost must be spread over the life of the books through annual depreciation); cost of attending meetings or conventions of professional groups (fares, room, board, tips, and registration fees); deductions from wages for state unemployment insurance taxes; deductions for sickness insurance taxes (in some states only); membership fees paid to association or professional group; employment agency fee to secure position; cost of periodicals or magazines, in connection with employment; telephone costs connected with position; cost of uniforms, laundering, and repair cost; and any other expenses which are directly connected with employment.

The hygienist, but not the assistant, has another deduction in the form of expenses for the rental, repair, or purchase of instruments and equipment. Again, if instruments and equipment are of long useful life, annual depreciation must be taken instead of deducting the entire cost in the year of purchase.

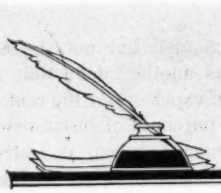
The expenses enumerated are those which have particular bearing upon those employed in dental offices; in addition, of course, are the usual expenses allowed to all classes of taxpayers (taxes, interest, charity, other expenses).

Unfortunately, the Treasury Department does not take your word for everything you deduct—so be on guard, keep a diary or some other record for the expenses which you incur, which are deductible.

Receipts or cancelled checks should be retained as proof of the entries made in your diary.

Today's tax laws are complex—care should be taken to take advantage of all deductions to which you are entitled to avoid overpaying your tax. When in doubt consult an attorney or a Certified Public Accountant.

69-07 224*th Street*
Bayside 64, *New York*



EDITORIAL COMMENT

"Give me the liberty to know, to utter, and to argue freely according to my conscience above all liberties." *John Milton*

HOW THE DENTIST MAY COMBAT "DECLINING DEMAND" FOR HIS SERVICES

A NEW euphemism has come into usage to describe the present economic situation: "declining demand." If words are tools that may be used to create emotional patterns "declining demand" is less harmful than the harsher expressions *recession* or *economic decline*. The more awesome words *panic* and *depression* have no place in the present vocabulary.

One economist gives this analysis of the current condition:

"Economists, as might be expected, are in disagreement as to how long the current slowing down in general business activity may last before bottoming out preparatory to upturn.

"There are some who look for the bottom about the middle of 1958. On the other hand, there are a few who look for the decline to continue for two years or more."[1]

The dentist is not immune from the forces that disturb the general economic atmosphere. He is fortunate because he does not have to participate *directly* in some of the distressing economic chores. He does not have to bargain to buy raw materials in the market. He suffers no direct threat from unemployment. He has no problems in advertising, marketing, distribution. His productivity is not threatened by strikes from suppliers of materials or from his employees. He is not required to go into the market to borrow money to keep a plant in operation. In short, the dentist is in a more favorable position than are most people in business.

Despite the enviable position that the dentist holds in economic society, he is *indirectly* involved in every shift in business sentiment. When high prices endanger the family budget people defer treatment.

[1]Commodity Report, The Journal of Commerce and Commercial, New York, **254**:1 (December 18) 1957.

except for immediate dental problems. When unemployment increases and purchasing power is reduced consumers are driven from the dental market. The people who live on dividends have already felt the pinch from the unrest in the stock market.

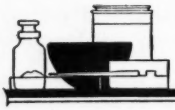
The businessman who finds himself faced with "declining demand" can step up his sales effort and promotion activities. Not so the dentist. He cannot advertise with more vigor or do a job of more aggressive selling. Such activities are forbidden. The dentist can, however, increase his productivity and his efficiency by making more use of the modern instruments that are available to him to speed up his work and at the same time help him to perform his services with less strain to the patient and to himself.

Although dentists do not compete with each other in the sense that manufacturers and retail businessmen compete, the fact stands that dentists compete for good will and patronage with more subtle devices. The dentist who can operate with more comfort to the patient is certainly in a more favorable position to encourage patronage than is the dentist who *thinks that he* does not have to keep pace with modern advancements in dental technology and pharmacology.

The public is becoming well aware of the newer high-speed techniques and the application of modern pharmaceuticals in dental practice. The dentist who delays too long in adopting some one of the present methods for high-speed tooth reduction will find many of his patients seeking the service of another dentist who is using the modern equipment. Anything that shortens the time of dental treatment and lessens discomfort will be readily sought by patients. It is unlikely that people will be coming into the dental office asking for a particular technique, instrument, or drug "by name." They will soon learn, however, from hearsay or by direct experience if the dentist is using modern instruments and pharmaceuticals.

One way for the dentist to combat "declining demand" for his services is to increase his efficiency, reduce the time for dental treatment, and lessen the discomfort of the dental experience.

Edward J. Ryan



TECHNIQUE of the Month

Originated by W. EARLE CRAIG, DDS

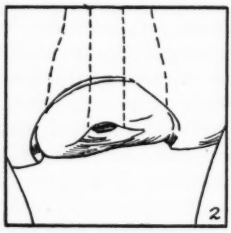
Dowel Acrylic Crown Technique

By JOSEPH PLUMBO, DDS, USPHS

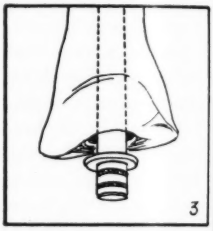
Drawings by Dorothy Sterling



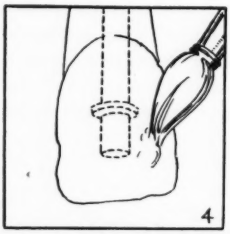
Take X-ray. Check periapical area and root canal filling. Use X-ray to select the proper size of manufactured platinum dowel.



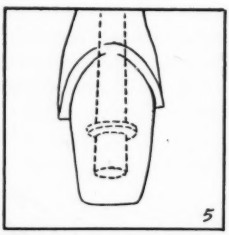
Cut tooth down to just below the margin of the free gingiva. Remove part of root canal filling with tapered fissure or round bur.



Fit manufactured dowel into canal. Cement in place.



Paint on self-curing acrylic in sufficient bulk to permit cutting down to a conventional jacket crown preparation.



Make conventional jacket crown preparation. Take copper tube impression and continue routine procedure for jacket crown.

Note to Contributors

We invite dentists to submit material for this page. $10.00 will be paid for each technique used. It is not necessary to make finished drawings—or even sketches—if you explain the procedure clearly, in detail, in your letter. Submit material to:

Technique of the Month,
Oral Hygiene,
1005 Liberty Avenue,
Pittsburgh, Pennsylvania

Q ASK Oral Hygiene A

Please communicate directly with the department Editor, V. Clyde Smedley, DDS, 1206 Republic Building, Denver, Colorado, enclosing postage for a personal reply.

Monilia Albicans

Q.—More than a year ago we delivered acrylic upper and lower dentures to a patient about forty years of age. Almost from the first she complained of constant burning sensations, particularly in the lower jaw, more prevalent at some times than others.

Three months ago we reproduced the lower denture in vulcanite, hoping for a favorable result; however, the same sensation persists.

We feel that we have developed a well-fitting denture. The patient is having no trouble with sore spots, nor in her masticating. Can you give me some advice as to local or systemic treatment for this particular case?—C.G.S., Nebraska.

A.—You do not say whether the mucosa is inflamed under these dentures, nor if you have tried leaving the dentures out to see if the burning sensation would clear up. You have found out what we believe; that is, that there is not likely to be any allergic reaction to acrylic dentures. The condition could be due to lack of Vitamin B, and it would be all right to prescribe Vitamin B Complex in this case.

There is, however, another condition which we find rather commonly, Monilia Albicans. The remedy is to thoroughly cleanse the tissue surface of the denture, and then dust this surface with Mycostatin® before returning the denture to the mouth. This treatment should be used each time the dentures are taken out for cleansing.—V. C. SMEDLEY.

Associate's Share of Fees

Q.—Recently I have shared my practice with a young associate who graduated from dental school last June. I have a 3-chair office. His salary was $687 in July, and $1088 in August. Now the building manager has asked me to give up the third operating room to allow more space to a surgeon who needs it.

I am 65 years of age, and work alternate months. I have one assistant. My associate wants to hire another assistant, as he thinks he can increase his output and income.

If I furnish a second assistant, pay the rent, and provide all supplies and laboratory equipment, what kind of a contract should I make with him?—C.C.G., Kansas.

A.—Your letter does not make clear to me just what your present situation is. Have you already complied with your landlord's request to give up your third operating room? Two dentists sharing an office should have at least three chairs, preferably four.

If your associate is with you on a percentage basis, which his earnings for July and August would indicate, with a personal assistant he

should increase not only his own output and income, but also yours.

I think a forty to sixty per cent split of fees collected is customary in such a situation, with perhaps fifty per cent most common.

If he is planning to build a personal practice from your practice and leave you in a year or two, his percentage should be less than if he is staying with you permanently.—V. C. SMEDLEY.

Centric Relations in Dentures

Q.—As soon as I have established a desirable vertical dimension by heating the lower bite rim and having the patient close into it with the chilled upper rim on which the plane has more or less been established, I proceed to take centric. After I near the desired vertical, either by bite gauge measurement before extractions, or by checking facial appearance. I start having the patient practice retruding the mandible by twisting the tongue back to touch the end of the upper base plate, and by instructing him to "move upper jaw forward," or "bite on back teeth," whichever is more applicable to the patient. When the desired vertical dimension is obtained, I then attempt to get the patient in the most unstrained retruded position by the foregoing methods, and by guiding the mandible with either the thumb and index finger of one hand, or with the index finger of each hand on the buccal of the lower rim and the thumbs under the jaw on each side.

Of course, I always attempt to have the wax on the lower rim soft when taking centric to equalize pressure and to have a bite without pressure. If the try-in shows the teeth are not in correct cusp groove relationship, or that the patient is not in the most retruded position, I take check bites and remount the lower, as much as necessary, by placing compound on lingual of upper anteriors and having the patient close n the most retruded position. Compound is then placed on the occlusal of the upper molars of the side or sides not in contact, and the patient again closes, and case is remounted.

A. If done properly, is this method as satisfactory as any other in making complete dentures, excluding the elaborate and detailed techniques?

B. Is centric relationship established as satisfactorily as it is by using devices?

C. What causes heavy molar occlusion in (1) try-ins, (2) finished dentures in which the bite appeared all right in the try-in, and (3) the finished dentures when they are inserted following satisfactory wax try-in, and the closed mouth impression taken by washing inside the lower base plate?

D. Will you advise as to a good and proper technique for obtaining centric relation for:

1. Full upper denture against lower partial removable.

2. Full upper denture against lower natural dentition.

3. The reverse of 1 and 2.

I shall appreciate your prompt and considerate attention. I read your articles every month without fail, and benefit greatly from your answers.—W.J.K., Texas.

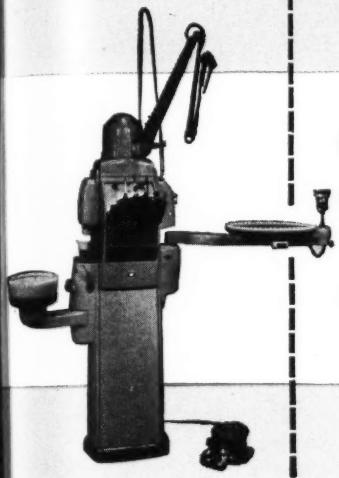
A. The procedure you describe for establishing centric for full dentures seems sensible and sound and should prove satisfactory in most cases. I have just two suggestions that I think you can adopt with benefit. Never use the word, "bite," when instructing a patient. In my practice, patients are more likely to thrust the mandible forward to an incising posi-

(*Continued on page* 64)

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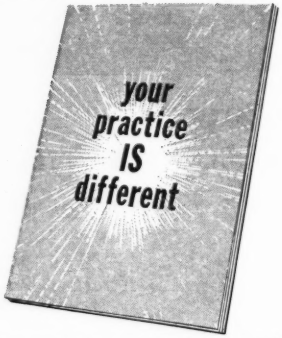
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tion when told to bite. I say, "Close on the back teeth," or preferably, in most cases, just tell them to swallow. The mere act of swallowing will usually carry the jaw to its most retruded correct centric position; and if the occluding wax is sufficiently and uniformly soft, the swallowing act will usually establish the correct opening also.

B. I feel that in most cases I am able to serve my patients as well or better with a simple procedure such as you and I have outlined here, than I would or could with any of the elaborate devices and complicated techniques that are taught and advocated by different enthusiastic prosthodontists. However, I am not saying that these men may not deliver a better and more scientific service.

C. Overpacking with intrusion of the posterior teeth into the flasking plaster or stone is probably the principal cause of this annoying occurrence.

D. The same principle applies in establishing jaw relations, whether you are constructing full dentures against full dentures, partials, or natural teeth, in whatever combination you use.—V. C. SMEDLEY.

Radiation

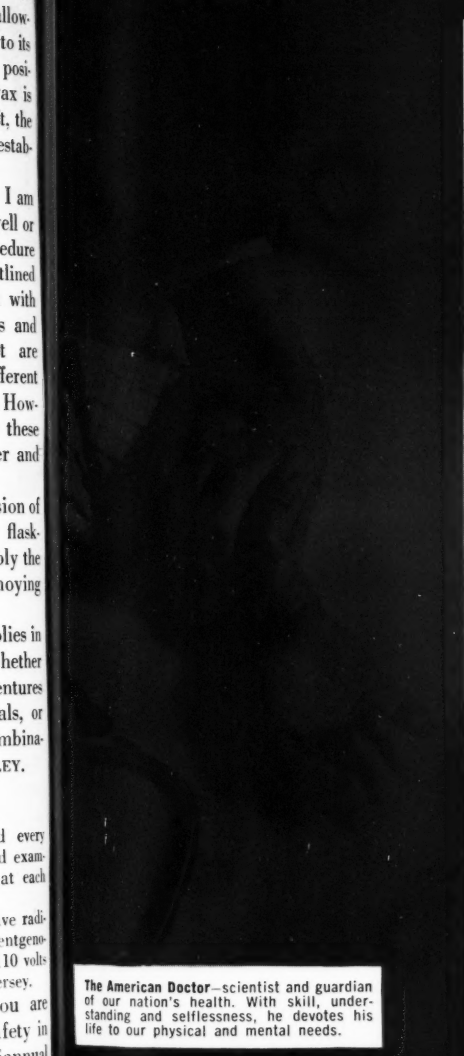
Q.—My patients are recalled every six months for a prophylaxis and examination. Four x-rays are taken at each 6-month checkup.

Is there any danger of excessive radiation from the total of eight roentgenograms per year at 10 amperes, 110 volts and ¾ seconds? J.A.H., New Jersey.

A.—I feel quite sure you are well within the limits of safety in dental x-rays with your semiannual bite-wing examinations.

(*Continued on page* 66)

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The foregoing view is supported by a recent experiment.[1]—V. C. SMEDLEY.

Gingivosis

Q.—I have a patient 55 years of age who has a peeling condition of his gingiva. Blisters form, and it resembles a burn. The area bleeds easily, and the surface of the gingiva sloughs off and refuses to heal. The condition has extended to his throat, and he has some eruptions on his chest. His physician claims that it is "nerves."

Any enlightenment that you could give regarding such a condition would be appreciated.—B.A.H., Wisconsin.

A.—The condition of the gingiva which you describe in your 55-year-old patient is characteristic of chronic desquamative gingivitis, called by a recent writer[2] gingivosis.

This condition occurs more commonly in the mouths of women, and about the period of the menopause. I have never seen it in edentulous areas, nor have I seen it in the throat. The condition of the throat and chest may be coincidental, and without seeing the case I could not suggest what it is.

The cause of desquamative gingivitis is not known, but its course is usually long and without any satisfactory response to treatment.

The gingivae should not be

(*Continued on page 68*)

[1]Budowsky, Jack; Piro, J. D.; Zegarelli, E. V.; Kutscher, A. H.; Hyman, G. H.; Tiburcio, Ana: Study on Effect of Exposure to Radiation, JADA **55**:199 (August) 1957.

[2]Orban, V. J., and Wentz, F. M.: Atlas of Clinical Pathology of the Oral Mucous Membrane, St. Louis, The C. V. Mosby Company, 1955.

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1. GALE, Dent. Rec. 71:15 and 71:184, 1951

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brushed nor irritated in any way. One writer[3] suggests the use of Vitamin A and "estrogenic hormones by direct application to the tissues, oral administration, or injection... However, since other systemic effects are usually produced the dentist and physician must cooperate in such treatment."—V. C. SMEDLEY.

Painful Pemphigus

Q.—I have a case of pemphigus and should like to know how to treat it. The patient is a woman of about 40. She came to the office about two weeks ago and had been treated by a local physician but without results. I thought it was thrush, and so treated it for a couple of days but decided in that length of time that it was not thrush. I sent her to a skin specialist, who diagnosed it as pemphigus.—F.F.T., Nebraska

A.—If your case of pemphigus is confined to the mouth, there are bulbous lesions in the mucosa and when they rupture they are painful.

According to a fairly late publication it has been found that cortisone systemically tends to alleviate the symptoms and severity of the disease although it is not a cure. I quote: "Lately, Naphuride Sodium injected intravenously in 1.0 Gm. weekly doses has been reported to cause symptomatic improvement. Palliative local measures include use of either warm sodium bicarbonate mouth rinses or warm-water solutions of molasses as wash to reduce pain. Anesthetic troches (benzocaine) will aid in the taking of nourishment."[4]—V. C. SMEDLEY.

[3]Miller, S. C.: Textbook of Periodontia, Philadelphia, The Blakiston Company, 1950.
[4]Orban, V. J. and Wentz, F. M.: Atlas of Clinical Pathology of the Oral Mucous Membrane, The C. V. Mosby Company, 1953.

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Dentists in the NEWS

Memphis (Tennessee) Commercial Appeal: Lieutenant Robert J. Adams (DC) USN, will spend the better part of the next two years analyzing and organizing data he brought home from a year spent at Little America. Lieutenant Adams was one of two dentists selected to go to Little America out of 1800 Navy dentists.

During the ten months Lieutenant Adams was stationed at Little America, he studied thermal, nutritional, and psychologic stresses. The coldest temperature he experienced was 67 below zero. "The 'buddy system' was mandatory when one went outside," he said, "for one could fall in a crevasse or any number of things could happen that made such a system a necessity."

When Lieutenant Adams has finished organizing the results of his work, he will make a lecture tour of Naval dental facilities in the United States, bringing his new knowledge to those who will put it into valuable use in the future.

Paris (France) World Veteran: In 1940 Doctor Jacques Bautruche, a dental surgeon of Paris, thought he would have to give up his profession. His right arm was wounded by a shell splinter, and his left by machine-gun fire. While being held prisoner of the Germans in a hospital at Namur, his right arm was amputated after gangrene set in.

But Providence intervened in the form of a ward-mate who had suffered the same wounds. "The lad saw that I was feeling very low," said Doctor Bautruche. "He told me he had a toothache, but he had not much confidence in my German colleagues. But that was only a clever way of getting me to resume my professional activity."

Gradually, as he treated his fellow-patients, Doctor Bautruche's confidence returned. Upon his liberation a few months later, he resumed his practice, although his re-education had been delayed by a series of eleven operations.

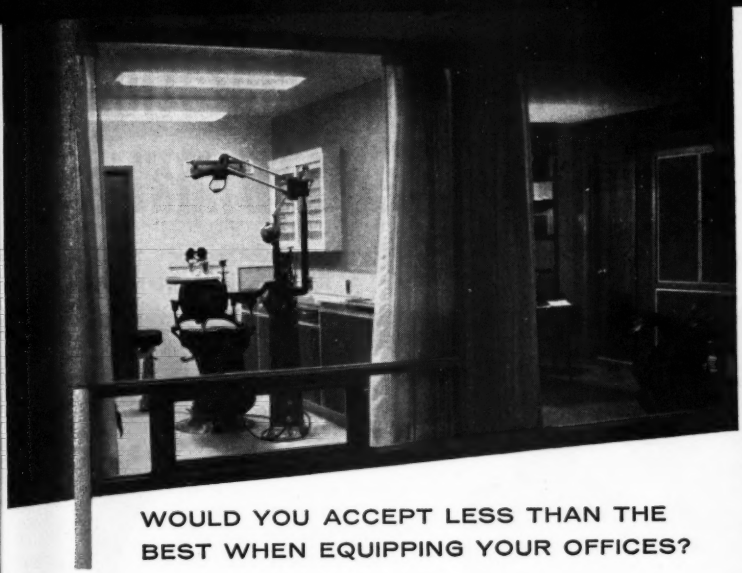
Philadelphia (Pennsylvania) Jewish Exponent: The University of Mexico Dental School has presented Doctor Sidney Felix of Philadelphia, with an honorary degree. Doctor Felix was given the citation after addressing the staff of the Military Hospital in Mexico City. He spoke on procedures in restorative surgery.

Los Angeles (California) Times: A group of sixteen business and professional people recently completed a 100-day trip around the world in a twin-engine Catalina, which has been named the *Spirit of Magellan.* Among the passengers was Doctor Norman H. Denner, a Cleveland dentist.

The amphibian plane took off from Long Beach Municipal Airport on November 23rd, and left American shores from Georgia, bound for Bermuda. The schedule called for stops in the Azores, Europe, India, Southeast Asia, Australia; then over the South Seas on the way back to Southern California.

Kansas City (Missouri) Star: There is nothing like combining your career with marriage, say Constance and Kenneth Givans of Kansas City, Missouri. They are both attending the University of Kansas City dental college, and will go into practice together when they graduate. Kenneth selected the field of

(*Continued on page* 74)



WOULD YOU ACCEPT LESS THAN THE BEST WHEN EQUIPPING YOUR OFFICES?

Of course you wouldn't because inferior equipment would not allow you to fully utilize your highly developed professional ability. And, too, you know that in the long run the best often costs little more than the ordinary. So it is with *denture base materials*—the best costs so little extra—so little extra to have the material your skill and high standards warrant.

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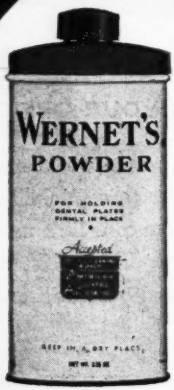
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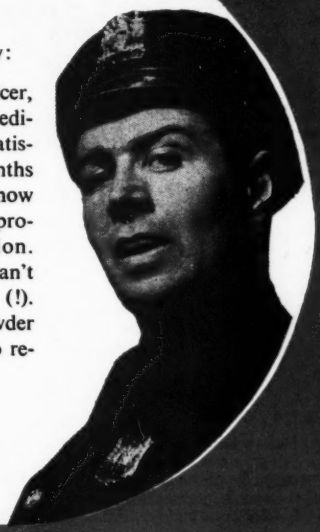
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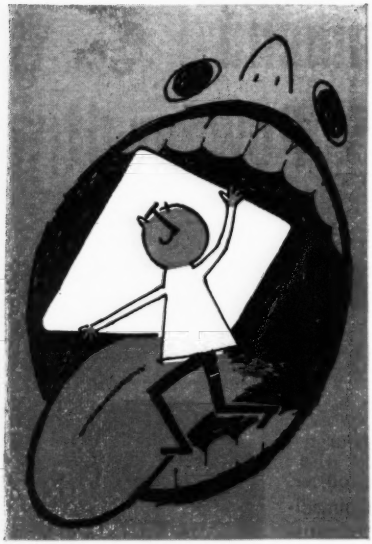
this patient . . . . . .



- A typical case history:
- JBL, city police officer, 48 years old. Had immediate dentures placed satisfactorily three months ago. Gum resorption now makes them wobble, produces some irritation. Biggest complaint: can't blow police whistle (!). Using Wernet's Powder until it is practical to reline dentures.

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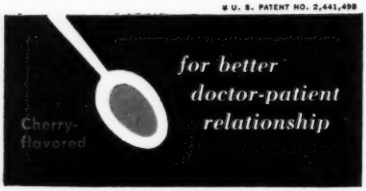
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Astra Pharmaceutical Products, Inc.
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* U. S. PATENT NO. 2,441,498



criminology when he began his studies. As a result, he now keeps exacting records of all his dental patients, and may later be able to relate the two fields, because dentistry is often the final proof of identification in criminal cases.

The only other woman enrolled in the dental school is Mrs. Philippe Carle, who will have two more years of study before finishing dental school in France. She is here to observe classes and procedure at the clinic. "At the start of the course, 50 per cent of the dental students in France are women," Mrs. Carle said. "Many marry and do not finish school, but still the postwar manpower shortage has put women in such professions permanently."

Chicago (Illinois) Tribune: Doctor George C. Mullen of Evanston, has assembled a complete collection of Royal Copenhagen porcelain Christmas plates.

"My mother," explained Doctor Mullen, "was a buyer of China, and taught me the various hallmarks of valuable pieces." It followed that Doctor Mullen should recognize the Royal Copenhagen Yul plates when he saw them in the home of a family friend. The hostess explained to him that he was the first person entering her house to recognize the plates. She presented him with the first two plates, and told him that it would be almost impossible to fill in the missing ones from 1910 to 1950. Three years of haunting pawn shops, antique shops, and auctions, were rewarded with but a few items. Then one of his patients, while touring Europe, purchased a collection for him which filled in the missing plates. The most valuable piece in the collection is Angel plate, designed as " a peaceful motif" in 1945. It is now worth $400.

The Royal Copenhagen Poreclain Company has informed Doctor Mullen that they did not know of another complete collection in this part of the country, outside of those held in museums.

Cleveland (Ohio) News: Governor C. William O'Neill has named Doctor Nathan K. Christopher as a trustee of Central State College at Wilberforce for the term ending June 30, 1960.

(*Continued on page 76*)



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Now . . . an absorbable hemostatic in conical tablet form for use in exodontia and oral surgery—

- completely absorbable . . . eliminates return visit
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San Antonio (Texas) Light: Doctor J. T. Sepulveda, 37, a dentist, formerly of Laredo, has been appointed by Governor Daniel to serve on a committee to study problems of the aged.

Awards for items submitted for this month's DENTISTS IN THE NEWS have been sent to:

Myron S. Rothenberg, DDS, 133-29 230th Street, Laurelton 13, Long Island, New York

B. Vellat, 508 West 62nd Street, Seattle 7, Washington

Colonel William Perry, Ret., Rittenhouse Claridge, 18th and Walnut Streets, Philadelphia 3, Pennsylvania

Alfred Burnsworth, 207 Lane K, Sunflower, Kansas

M. Travascio, 934 North 63rd Street, Philadelphia 31, Pennsylvania

John T. Kenney, 1286 Jackson Avenue, Lakewood 7, Ohio

Philip F. Angelot, Office of C.G. Hq. 4th Army, Fort Sam Houston, Texas

CAN YOU USE A DOLLAR?

TO EVERY READER who contributes a newsworthy item, something unusual about a dentist, *which is published in Dentists in the News,* we will send promptly a crisp, new one-dollar bill. Every clipping must be taken from a newspaper and carry the name of the publication and the date line. Clippings submitted cannot be returned. When more than one copy of a clipping is submitted, the first one received will be used. Send all items to Dentists in the News, ORAL HYGIENE, 708 Church Street, Evanston, Illinois.

ORTHODONTICS

- The next postgraduate course in orthodontics for the general practitioner will start on May 5, 1958.
- A limited number of applications can still be accepted.
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DEAR ORAL HYGIENE

Letter from Bolivia

I thought you would like to know that a number of my colleagues have congratulated me on my COMMENTS ON DENTAL ECONOMICS IN BOLIVIA, which you were kind enough to publish in the Spanish edition of ORAL HYGIENE, last September.

I also have some good news to report. This year I will be closer to the United States. At the suggestion of a Venezuelan professor who is now teaching at the University of Bolivia, I have decided to go to Venezuela to practice dentistry. A dental reciprocity agreement has been signed between the Bolivarian countries. Colombia, Bolivia, Ecuador, and Venezuela. I will, therefore, be able to practice dentistry in Venezuela without revalidating my degree by attending dental school in Caracas or taking an examination.—*Luis Ml. Zubieta Reguerín, Casilla* 295, *La Paz, Bolivia, South America.*

Reciprocity

The series of articles by Doctor George A. Holmes constitutes one of the finest contributions that has been made to date in the discussion on dental reciprocity.[1]

If after reading these articles there is any dentist alive who still believes that our present system of licensing is just and equitable, someone should take him aside and explain the important facts of life to him. By that I mean the facts of life in 1957: that we are a restless, as well as a rootless Nation. Fully 34 million Americans will this year move to different locations.

If a man owns a grocery store or gasoline station, he can move his business to Timbuktu in order to add to his profits, without an objection being raised; but if a dentist wants to move to another state he is labelled a carpetbagger and denied admittance.

The dentists in this country "mutually reciprocate their clinical findings as

---

[1]Holmes, G. A.: Should There Be Dental Reciprocity in the United States? ORAL HYGIENE **47**:44, 52, 57, 48 (September through December) 1957.

well as their scientific research." At our national conventions there is a remarkable atmosphere of conviviality and good fellowship. But when a dentist wants to relocate he finds that each of the forty-eight states is fenced as with a Chinese wall.

At a time when everyone in this shrinking world should be thinking globally, *we* are still committed to the principle of States Rights in dental licensure. This is not a question of States Rights with which we are dealing. We are dealing with *human* rights.

If many of the older men are unable to pass the written examinations it is because "In general, theoretical studies are harder to master after the age of 30 is passed." (*Journal of the American Medical Association,* Editorial) And if any are found to be unsure of some of their clinical skills it is because much that has been learned in dental school is prone to atrophy with disuse.

These shortcomings, however, should not bar a dentist from practicing in another state. The only criterion should be that of character. Reputable dentists are always aware of their limitations. This is attested by the constant stream of referrals to the numerous specialists who are flourishing in our midst.

By your excellent presentation of the articles on reciprocity much good has been accomplished in keeping the question alive. We should now call on the American Dental Association to think through this problem, to grapple honestly and courageously with it, and to begin the great task now of establishing genuine reciprocity—instead of the present travesty.

"A dentist who brings credentials of good standing at the time of departure should be welcomed as a brother, treated as such in any state, and registered upon payment of the usual fee."

That a practitioner registered in one state cannot practice in another state, as Osler put it "without submitting to vexacious penalties of mind and pocket is, I maintain, an outrage; it is provincialism run riot."—PHILIP PARKER, DDS, 1801 *Marmion Avenue, Bronx* 60, *New York.*

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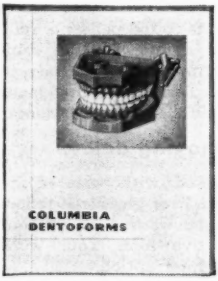
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ANSWERS TO QUIZ CLXII

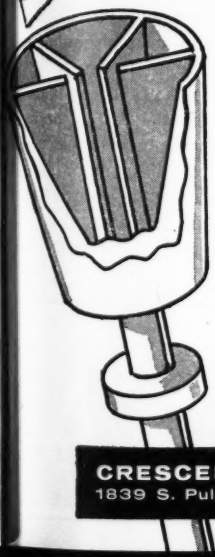
(See page 45 for questions)

1. (a). (Accepted Dental Remedies, 22nd Ed, American Dental Association, 1957, page 137)
2. It can destroy tissues under dentures. (Gieler, C. W.: Immediate Dentures and the Successful Management of the Patient Who Needs Them, Illinois D. J. **24**:800 December 1955)
3. (a). (Doerr, R. E.: The Use of Increased Speeds for Rotating Instruments, Jour. S. Cal. Dent. Assoc. **24**:30 May 1956)
4. True. (Colpoys, F. L.: Medical Evaluation of the Dental Patient, Mass. D. Soc. J. **5**: 9-10 April 1956)
5. (a). (Linghorne, W. J.: Studies in Regeneration and Reattachment of Supporting Structures of the Teeth, J. Canad. D. A. **20**:673 December 1954)
6. No. (Russ, H. C.: Oral Leukoplakia, J. Oral Surgery **15**: 40 January 1956)
7. (a). (Ingle, J. I.: Determination of Occlusal Discrepancies, JADA **54**:7 January 1957)
8. No. Almost nonexistent. (Barker, T. K. and Renfroe, E. W.: Interceptive Orthodontics for the General Practitioner, JADA **54**:328 November 1957)

(*Continued on page* 82)

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Two Effective Guides To Better Denture Construction

FULL DENTURES

By CHESTER LANDY, D.M.D., Assistant in Dental Surgery (Prosthetic Section), Beth Israel Hospital, Boston.

1958, 182 pages, 4 7/8" x 7 5/8", 82 illus. Price, $5.85.

A concise, readily-available reference on full denture construction, FULL DENTURES extracts one sound, clinically-tried technique from the mass of information for full denture construction and describes it in full, explicit detail. You may want to adopt it in its entirety or utilize only parts to improve your present technique. This helpful reference describes such recent advances as non-anatomic teeth and the muco-static or minimal pressure impression technique. In addition, denture base materials, the adjunct use of drugs, single denture, and post insertion adjustments are covered.

PARTIAL DENTURES

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By KENNETH P. AUSTIN, D.D.S., F.I.C.D., Associate Professor, University of Oregon Dental School; and ERNEST F. LIDGE, JR., D.D.S., B.S.

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Covering recent valuable concepts, PARTIAL DENTURES presents a practical, simple technique for constructing partial dentures. Clear and well-illustrated, here is a step-by-step description of the technique in the construction of a partial prosthesis from the first examination to the completed case. Particularly valuable is a comprehensive section on "Trouble Shooting".

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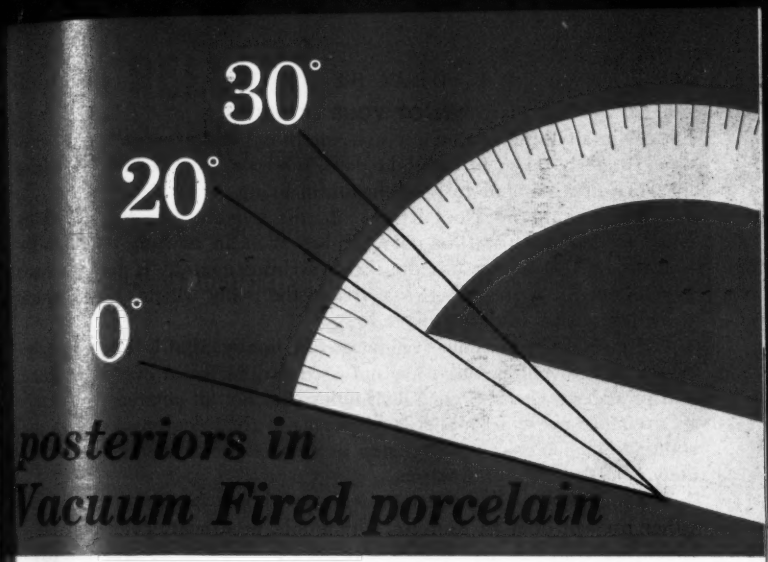
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9. True. (Ney Bridge & Inlay Book, J. M. Ney Company, Hartford, Connecticut, 1954, page 61)
10. Yes. (Willey, R. E.: The Preparation of Abutments for Veneer Retainers, JADA 53: 142 August 1956)

THE PHANTOM OF FEAR

CONTEMPORARY man, like the pagan peoples mentioned in Scripture, manufactures his own idols and then worships them. These idols of the contemporary market place are called Progress, Science, Technology, Productivity, Democracy, Right, Solidarity, Evolution, Socialism, Communism, to mention but some. The two World Wars which our generation has known and undergone, the international tension which followed them, and which is relaxed in one direction only to be increased in another, have introduced into the contemporary world the phantom of fear, and man has not yet sensed that he is handling explosives that he can ill control, and he has not relearned the benefits of the virtue of humility.—ABBE EUGENE JARRY, The Church in the Present Century, *Thought Magazine*, Fordham University.





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"ENJOY YOUR EXERCISE"

Excess in anything can be a wearisome thing, and exercise is no exception. Properly taken in the right dose, however, exercise can be one of the greatest stimulants to good, healthful living.

What is exercise? Does it mean to the sedentary worker thirty-six hours of golf the first time out? Or does it mean bowling ten lines the first time to get in trim for the season? Unfortunately, it does to many people, but these are only two sports of the many which give pleasures to children and adults alike.

Exercise can be considered in terms of a hobby; that is, any game that gives play to muscles that are not used ordinarily in everyday living, and provides a cheerful mental stimulus. But not all persons can engage in strenuous sports or activities requiring a great degree of energy and stamina. That is why the first step in using exercise wisely and moderately is a physical examination.

A good physical examination will reveal any condition that might either prevent or limit exercise. This might be a heart defect, or nutritional inadequacies that would retard the body from meeting the strain called for in certain types of play.

While certain games are seasonal, exercise for the individual person should not be seasonal, nor done in spurts. Exercise on a moderate scale can be maintained all year round, whether it be walking, bending, or performing mild calisthenics. The person who is inactive all winter and throws himself enthusiastically into long periods of swimming, golfing, and the like, is asking for trouble. Unused muscles shout their objection with aches and pains, so that what otherwise has been an enjoyable event results in many hours of misery and a feeling of real illness.

What does intelligently planned and controlled exercise do? It speeds up all the body processes—old cells are broken down, new cells are formed, and blood flow is increased, breathing is extended, and other functions are stimulated. Muscles are kept in good tone. Thus the chief value of exercise is improving the coordination of nerves and muscles, and stimulating the normal processes of the body for circulation and elimination.

Not all people in the same age group can take the same exercise. For this reason it is wise to let the results of a physical examination influence your physician's counsel in regulating your exercise. And then apply his advice. Remember that good health incorporates many things; adequate nutrition, good physical condition, and a normal mental outlook. Exercise is a means to maintain good health and zestful living.

Avoid excessive fatigue. Stop activity at the point of pleasantness so the activity will be a source of real enjoyment.—Joseph Pennepacker, MD, *Montana Health*

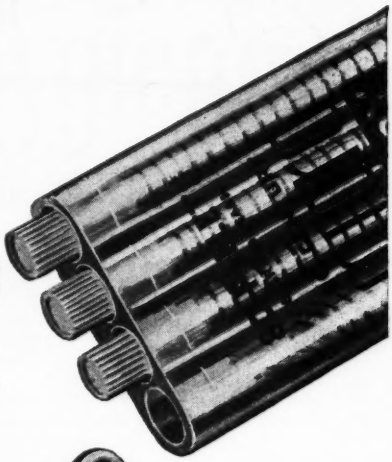
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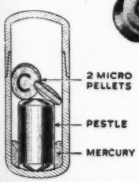
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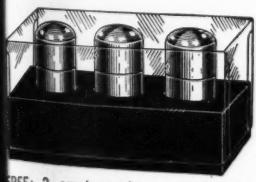
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Sam: "Your girl's spoiled, isn't she?"

Jim: "No, it's just the perfume she's wearing."

★

The father asked the boy to be good while he was away. "I'll be good for a nickel," said the boy.

"You'll never be a real son of mine until you're good for nothing."

★

An Air Force master sergeant in North Africa was briefing his fellow Texans. "Our job here is to promote goodwill. We've got to be polite with the natives. So, if any of them tell you that Africa is bigger than Texas—just agree with them."

★

Sign on the office door: "If you have anything to say lower your voice and slip it under the door."

★

A fellow had had a drink or so too many and was driving the wrong way on a one-way street. The traffic officer asked him the inevitable question:

"Where do you think you're going, Bud?"

"I'm not sure," he answered, "but I must be late. Everybody's coming back."

★

The wedding ceremony was at an end. The bride dabbed at her pretty eyes with a filmy handkerchief. One of the bridesmaids was also affected to tears. "Why do you weep?" asked a gentleman guest. "It's not your wedding."

The girl looked at him scornfully. "That's the reason!" she snapped.

★

The old Professor at the college was attending the unveiling of a bust of himself. After the ceremonies, a pretty young lady walked up to him.

"I hope you appreciate me," she cooed, "I have come fifty miles to see your bust unveiled."

"My dear young lady," gallantly replied the professor. "I would travel a hundred miles to see yours."

★

"Did you hear about the man whose cat got run over by a steamroller? He didn't say a thing—he just stood there with a long puss."

★

Theirs was a beef stew marriage
If you don't mind descriptions crude.
His wife was always beefing,
And the husband always stewed.

★

The chorus girl swept into the dressing room with a mink coat draped casually over her arm.

"Dearie," asked one of the other girls, "how did you ever get such a gorgeous mink? Why, I've been struggling for years to get one."

"Honey," replied the other, "you mustn't struggle . . . ever."

★

There was the dear old lady who sent her pastor a box of assorted goodies with this note: "Dear Pastor: Knowing that you do not eat sweets, I am sending candy to your wife, and nuts to you."

★

Customer: "I don't like all the flies in here."

Waiter: "Just pick out the ones you don't like sir, and I'll throw them out."

★

Mother—"Did I see you kissing that young Allen last night?" ?

Beryl—"Well, Mother, he told me he had just lost an uncle and I felt so sorry for him."

Mother—"If I know anything about that young man he won't have a relative left in a week's time!"